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ABSTRACT

This special edition summarizes the discussions which proceeded during the Indian Health Service (IHS) Mental Health Plenary Session. Following introductory comments by four session participants are seven discussion topics: mental health status of American Indians and Alaska Natives; history and description of the program; services for children and adolescents; evaluation and research findings, needs for evaluation and reporting systems; organization and funding; contracting under P.L. 93-638 (Indian Self-Determination and Education Assistance Act); and accomplishments, mission and future direction of the IHS Mental Health Program. Each discussion includes remarks by that topic's presenters and are followed by comments from other participants and further comments by panelists. Most discussions have opening comments from a moderator. Attachments include Plenary Session Agenda, summary statement by the chairperson concerning mental health services for children and adolescents, a list of plenary session participants, mental health recommendations which include nine recommended actions and comments over the recommended actions, Dr. Everette Rhoades' recommendations, and a response to recommendations to the Ad Hoc Group on Mental Health. Closing comments by Dr. Rhoades from Discussion VII include 14 topics which were not discussed fully including cultural ties, genetic causality, the family, dichotomies, suicide, sharing of clinical experiences, accidents, and prevention. (PM)

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Attachments:

A - Plenary Session Agenda

B - Summary Statement by the Chairperson

C - List of Plenary Session Partipants

D - Mental Health Recommendations

E - Dr. Everette Rhodes (Recommendations)

F - Response to Recommendations to Ad Hoc Group on Mental Health

INTRODUCTION

In February, 1984, the Mental Health Programs Branch, Indian Health Service, published a special issue of the Listening Post which included the material that had been developed for the Plenary Session of the Mental Health Program Review. From the Plenary Session a Summary Report was developed. An Ad Hoc Group on Mental Health was subsequently convened to make recommendations to the Director, Indian Health Service, based on the discussions that went on during the review process and which are contained in the summary report. The Ad Hoc Group made its recommendations on July 9, 1984. Shortly thereafter, Dr. Everette R. Rhodes, Director, IHS, and Dr. Robert Graham, Director, HRSA responded with their recommendations to the Mental Health Programs Branch. In November, 1984, the Mental Health Programs Branch issued a progress report to the Office of Program Operations, IHS, concerning planned actions in response to their recommendations.

This special issue of the Listening Post, contains the above documents in their chronological order. The Mental Health Programs Branch is issuing this volume as a followup to the February, 1984 issue and the HRSA review process.

William B. Hunter, M.D.
Acting Chief, Mental
Health Programs Branch

SUMMARY REPORT

INDIAN HEALTH SERVICE MENTAL HEALTH PROGRAM REVIEW

PLENARY SESSION

Portland, Oregon

January 17-19, 1984

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service

The review was planned and conducted jointly by staff of the Indian Health Service and the Office of the Administrator, Health Resources and Services Administration.

May 1984

INDIAN HEALTH SERVICE MENTAL HEALTH PROGRAM REVIEW

SUMMARY REPORT OF THE PLENARY SESSION

January 17-19, 1984

The Program Review Process

Program review is a management tool adopted by the Health Resources and Services Administration (continuing a practice begun in one of its predecessor organizations) as a means to improve decision-making about selected programs. The term "program review" refers to a three-part process beginning with a period of preparation lasting several weeks or months, which starts with an identification of significant issues concerning the program. Information about the legislative and operational history of the program is gathered and summarized in relation to the issues.

The second step is a two or three day meeting, or "plenary session," which typically includes line managers, other DHHS line and staff officials, and others who are knowledgeable in the field but who are not directly connected with the program, such as university-based researchers and practitioners. Based on the issues developed earlier, participants in the session discuss the philosophical and legislative base of the program and the national problems it was designed to address, its legislative and funding status, program history, and effectiveness. The objective is to give Agency managers the benefit of a broad set of perspectives concerning program accomplishments and problems from the interaction among participants who are selected to reflect a wide range of program-related interests.

Through an active interchange of views at the meeting, the participants as a group develop conclusions and recommendations for further action. These may be expressions of a group consensus or they may be the opinions of one person or a small group of participants.

The third phase is consideration of and action by the Agency on the conclusions and recommendations from the plenary session. A summary report of major points raised throughout the session is produced and sent to all participants for comment. Subsequently, the Agency sends a letter to all participants stating a response to each of the recommendations for further action. Agency staff then institute changes stemming from the plenary session and monitor the progress of implementation.

Content of This Report

This report is intended to summarize the key points raised by panelists and by other participants during the three-day plenary session, which concerned the Mental Health Program administered by the Indian Health Service. (Mental health services funded by other organizations were not reviewed.) It is based on materials from and comments of participants and on audio recordings. The content is organized according to the plenary session agenda, Attachment A. The agenda was based on major topic areas, or Discussions. In most cases, the moderator and a group of presentors gave initial comments which were followed by reactions from other participants and further comments from the panelists. The summaries of Discussions III-VI include both types of comments.

The remarks attributed to individuals represent their views. The "Comments from the Group Discussion" sections reflect points that were raised by one or more participants. Most do not imply consensus since, in many cases, other participants voiced different views.

The Mental Health Plenary Session provided a number of recommendations, although there was no attempt to reach a consensus on most of them. The summary of Discussion VII outlines the recommendations and observations shared by the group. Following this section of the report is a summary statement by the Chairperson, Dr. Irving Berlin (Attachment B).

The participants in the plenary session are listed in Attachment C.

Introductory Comments

Speakers: C. Stanley Stitt, Jr.
Robert Graham
Everett R. Rhoades
Irving N. Berlin

Dr. Stitt The IHS mental health professional staff reflect an impressive breadth of interests and talents. However, despite the work that has been done since the mid-sixties, the incidence of mental health problems is still incredibly high among Indian populations. Participants should focus especially on the magnitude of the problems and the limited resources available to address them.

Dr. Graham A program review is an effort to achieve a programmatic and organizational renewal. From the group should emerge a sense as to the appropriateness of the IHS approaches to the mental health problem and the adequacy of the resources. Mental health needs are clearly expanding. HRSA is committed to considering carefully any advice the group offers, in a spirit of willingness to make changes. Participants should be able to look back a year later and see evidence that some, if not most, of the recommendations of the group have been acted upon in a reasonable fashion.

Dr. Rhoades The goal of the IHS is to raise the health status of Indian people to the highest possible level. The definition of health for IHS is "ability of an individual to exist harmoniously with nature." Three missions stem from the IHS goal: (1) to provide high quality direct care, (2) to increase the participation of Indian people in the management of their own programs, and (3) to serve as an advocate for Indian people. There are three objectives relating to the first (clinical) mission: (1) to prevent premature death, (2) to prevent excess morbidity, and (3) to improve the quality of life for Indian people. These are accomplished by ministering to patients, conducting research, and teaching. (Dr. Rhoades noted that "doctor" means "teacher.")

Dr. Rhoades listed three personal goals for the plenary session: (1) to demonstrate again the high quality of IHS staff, (2) to bring together some of the constituents who have supported IHS in the past and continue the working relationship with them, and (3) to move the level of knowledge closer to the threshhold of dealing more effectively with behavioral abnormalities. He asked the group to think creatively about Indian mental health and to do so especially outside the context of its present organizational structure.

Dr. Berlin The disparity between the mandate to provide comprehensive mental health services called for in authorizing legislation and the limited resources which have been available has made planning difficult.

In 1977, the first American Indian conference concerned with children was held at Bottle Hollow, on Supportive Care, Custody, Placement, and Adoption of American Indian Children. This conference was conducted jointly by the Academy of Child Psychiatry, IHS, and several Indian health and social service organizations. Another significant meeting was held in 1979 in Warm Springs, Oregon, on A Case Study Approach to Recognizing the Strengths of American Indian and Alaska Native Families. This conference was a collaborative effort of the Academy and the Indian Judges Association.

It is particularly important to apply the data from the burgeoning field of infant and child development to formulating more effective methods of prevention, early intervention, and treatment for children, adolescents, and their parents. Treatment designed to enhance social, cognitive and ego development at any age is important to improved function and sense of self-worth. Seriously mentally ill children deserve every intervention indicated by a thorough psychiatric evaluation. Thus, stimulants, antipsychotic, antidepressive, and lithium medications should be used when indicated in inpatient settings.

Family involvement is essential where family members exist. The research in neurochemistry and neurophysiology promises to enrich our understanding not only of genetic and intrauterine neurochemical disturbances but also of how the environment alters cellular physiology. Such research also makes clear that most disorders, whatever their neurochemical base, arise in an interpersonal setting and require interpersonal interventions along with other treatment. It is increasingly clear that all illness - physical and especially mental - is multicausal in origin and requires a treatment approach which deals with the several etiologic factors.

There are some impressive efforts to understand psychiatric disorders in the terms of a particular culture's language to describe certain behaviors, such as depressive or psychotic symptoms, and to translate some definitions into terms meaningful to these cultures.

Diverse epidemiological studies have been helpful in delineating incidence and nature of various disorders. For example, a vital question is: Why do suicide, depression, and child abuse occur frequently on one reservation and not on another?

Education and resulting feelings of competence become mental health issues. In the last decade, it has become clear that Piaget's theory of an inevitable march of cognitive development is not always confirmed. Young adolescents do not always move from concrete to formal operations, that is, the ability to think in abstract terms. Research shows that 50 percent of adults and 40 percent of college students remain at the concrete stage of thinking. However, observations of the National Commission on Children and Youth's pilot projects indicate that problem-solving attitudes and abilities can be taught.

In all of these areas, there is a critical role in leadership and participation for Indian health, welfare, and mental health workers and Indian healers, elders, and other tribal leaders.

Discussion I

Mental Health Status of American Indians and Alaska Natives

Moderator: H. C. Townsley

Presenters: Joseph W. Ball
Carl A. Hammerschlag
James H. Shore

Dr. Townsley Of the ten leading causes of death among Indians, four are related to mental health and/or alcoholism: accidents, suicide, cirrhosis of the liver, and homicide. Over the past three decades, there have been tremendous improvements in the health status of Indian people, primarily in relation to organic diseases. Mental illness remains a problem of epidemic proportions, and treatment advances lag behind those pertaining to physical illness.

Dr. Shore It is important to recognize adjustments for age and sex in death rates when describing the epidemiology of Indian mental health. Young adults, especially males, are at highest risk from four major causes of death: accidents, suicide, homicide, and alcoholism. Patterns of morbidity tend to associate Indian males with alcoholism and women with depression and anxiety, although in some tribes, additional psychosomatic illnesses such as duodenal ulcers or arthritis may be prevalent. Tribal differences and cohort patterns are also significant in understanding patterns of suicide. For example, a study of an intermountain tribe showed a substantial increase in the suicide rate following World War II; a similar increase has also occurred in Alaska after new acculturation pressures associated with petroleum exploration and development.

Within a population, a small number of people carry the highest burden of the risk. The fact that in Indian communities this risk varies across extended families has important implications for the design of mental health programs, especially in relation to prevention.

Intertribal differences also need to be taken into account. Traditional culture and language affect perception and disease patterns. Migration to and from urban areas continues to contribute to cultural change and stress.

Symptoms of grief and mourning are common. Grief is extremely common because of the high number of fatal accidents. Some families suffer an unusually high number of deaths, and surviving members suffer from compounded stress and unresolved grief.

Traditional medicine is a symbol of tribal identity. For non-Indian mental health professionals, traditional medicine is an important collaborative point to increase one's sensitivity to cultural issues.

There are a number of culture-bound disorders that are associated with depressive behavior. To understand mental health issues, one must recognize tribal-specific behavior from the cultural point of view of the patients. Many culture-bound disorders should be re-examined. For instance, a recent review suggests that the Windigo psychosis among the Ojibwa, Cree, and Eskimos is an "anthropologist's disease" in that it appears in ethnographic literature but is without a documented clinical case example.* Other disorders are Wacinko, a condition of excessive pouting among the Oglala Sioux; the condition of "totally discouraged" among the Standing Rock Sioux; and hallucinatory mourning among the Hopi.

In studying epidemiology, one can gain understanding of cultural, behavioral, and biological etiologies of mental illness. One of the most common conditions is the relationship between depression and alcoholism among members of high-risk families. During the next decade, there will be an opportunity to learn much more about this relationship and the way stress, family relationships, culture, and biology affect these high-risk individuals.

In a research project, the American Indian Depression Study, Dr. Shore and colleagues are studying depression in five tribes on three reservations from several points of view: the individual's internal concept of depression, the depressive behavior that the subject experiences, alcohol-related behaviors, and somatic symptoms. The researchers have identified a number of unique Indian concepts of depression that were previously undescribed in Western literature. Only one of these concepts, "spiritual death," appears to be closely associated with a pattern that most psychiatrists would call "major depression."

One of the potential uses of this type of research in treating American Indians is in training staff who are not in the mental health field to recognize signs of depression and to make appropriate referrals. Since most mental health contacts within the IHS system are not with mental health personnel, there is a need to train IHS staff to respond appropriately. This type of research data can be used to develop protocols for identifying and treating mental illness.

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*A particularly clear discussion of Windigo appears in an article by the anthropologist who first described it: Hallowell, Irving, "Fear and Anxiety as Cultural and Individual Variables in a Primitive Society," Journal of Social Psychology, IX: 25-47, 1938.

Dr. Ball About half of the 1.5 million American Indian and Alaska Native populations live in urban areas. The IHS-funded Urban Indian Program in Portland is serving Indians who have a variety of mental disorders, although the program has insufficient staff as a function of a budget cut three years ago. Based on a survey during 1982 of a sample of clients in this program,* many come from backgrounds which include the following:

- Of the sample, 76% lived in the city and 21% lived in the suburbs.
- 41% were born on a reservation.
- 82% were tribally enrolled or officially recognized as tribal members; of these, 22% had never been on a reservation.
- 74% attended two or more pow wows a year.
- 47% had never had an Indian relative stay with them for more than two days.
- By age 15, 55% of the sample were no longer living with their natural parents.
- 50% reported assault by a stranger, and 45% by a family member. 48% had been assaulted by age 15.
- 12% had been sexually abused by a family member.
- 33% of the sample had been formally charged with assault by the legal authorities; of these, 1.5% had been charged with sexual abuse.
- 69% of the females had had an abortion and 43% had been pregnant by the age of 17.
- 24% had suffered loss of people to whom they were close by suicide or homicide.
- 26% were employed, 56% were unemployed, and 17% had a student status.
- 54% had graduated from high school.
- 60% had an income of $400 per month.

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*These data are based on questionnaires administered to a sample in which 60 tribes were represented, with Sioux, Navajo, and Cherokee being predominant. The statistics are taken from a paper, "Mental Health and the Urban American Indian -- the Need for Training and Internship," by Loye M. Ryan and Robert A. Ryan.

- Only 20% were receiving welfare payments.

- 62% reported use of alcohol and/or drugs to help them feel confident and relaxed.

- 44% reported having lost time from work due to drinking. 47% reported that use of alcohol and/or drugs interfered with family life. 53% of the sample had sought help for alcohol and/or drug abuse.

The primary diagnoses reflected in the charts of these clients in 1982 were: depression (21%), alcoholism (21%), schizophrenia (20%), adjustment reaction (18%), borderline personality (9%), family conflict (9%), and sexual identity (3%).

Major needs in Portland -- and, by inference, in mental health services for urban Indians elsewhere -- include (1) more involvement with children and adolescents, (2) a closer collaboration with alcoholism and other health and social services, (3) research, and (4) effective ways to address the isolation of these people.

Dr. Hammerschlag There is a need to consider the multi-dimensional ways of looking at the mind, how treatment can affect it, and how intervention can change the intricacies of human behavior. It is short-sighted to view the mind purely from a Western scientific research perspective. Results of scientific inquiries will always be less than what the mind is. There are some questions that have no answer.

There is much to be learned from the nature of the Indian experience. The knowledge already gained by IHS needs to be shared with the wider society, including the value of traditional approaches to influence the mind: ritual, laying down of cedar, playing of drums, and the taking of powerful sacraments.

Comments from the Group Discussion* There are perceived large unmet needs for mental health services among urban Indians; "these people fall between the cracks." Part of the difficulty is the unwillingness of health and social service agencies, units of state and local government, etc., to accept responsibility for treating or financing treatment for these people. This group lacks resources as individuals, and alternative financing is frequently not available. (The U.S. Conference of Mayors, for example, has said it cannot support urban Indian programs.) An additional factor is the degree to which Indians feel comfortable in using the non-Indian system.

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*Comments from the group, here and in later sections, represent opinion, not necessarily fact or consensus.

An ongoing study of 150 Indians in Seattle* who do not attend the local IHS alcoholism program shows that over 50 percent do have significant alcohol-related problems. The people in this sample also suffer from significant levels of depression and anxiety. The Indian population in Seattle totals 14,000-20,000. There is considerable seasonal migration among this group to and from a reservation, and also between locations within the metropolitan area. These people have no support system from the extended family.

Urban Indian programs and mental health services on reservations do not compete for funds within IHS, since they are supported by two separate line items. (The Mental Health Program is authorized in Section 201 (c)(4) of Public Law 94-437, September 30, 1976.) At the Congressional level, however, there is competition as part of the appropriations process. At the program level, there is no close tie between the urban and reservation programs.

Perhaps the IHS should have a policy on the relationship of traditional healing and IHS mental health services. Dr. Manson and Dr. Hammerschlag were asked to develop recommendations in this regard. It was noted that tribal views vary as to the desirability of integrating traditional healing methods into IHS programs.

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*This refers to research being conducted by Dr. Dale Walker under a grant from the National Institute on Alcohol Abuse and Alcoholism. The title of the study is "American Indian Alcohol Abuse and Treatment Outcome." A manuscript presenting interim findings is in preparation.

Discussion II

History and Description of the Program

Moderator: Billee VonFumetti

Presenters: Robert L. Bergman
John W. Bjork
Lindsley Williams

Dr. Bergman There are some lessons from the past, based on approaches that worked in the early years of the program. First, the staff at the three initial sites,* and at all other sites developed subsequently, functioned with a high degree of autonomy. Initially, this condition existed because the administrators who had expectations for these mental health efforts were physically far removed. Later, staff autonomy was guarded as an explicit policy of the national mental health office. The objective was to recruit the best people and allow them to function flexibly in responding to the needs of their Area or Service Unit.

Second, systematic recruitment and training of Indians for paraprofessional positions were extremely significant. Selection was based on knowledge of language, local conditions, and cultures. The program must continue to recruit creative local people and foster their development in the mental health field.

Third, traditional Indian healing methods were useful in many cases; IHS staff referred patients to medicine people on occasion. (Medicine people, in turn, often referred to the IHS staff.) There was little success with bringing Indian healers into non-Indian institutions to function as healers. What worked best was the hiring of medicine people to teach and consult with the IHS staff.

Fourth, from the beginning the program offered the broad range of services now termed "community support programs." The mental health technicians have always gone out into local communities and spent time with disturbed people and their support network. In one instance, a mental health worker persuaded the manager of a store to begin cashing welfare checks for local Indians in anticipation of expanded business. Consequently, the Indian families in the area had a new

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*The first psychiatrists, hired to begin a mental health program in three locations, were Robert Bergman, Joseph Bloom, and Carl Mendel.

convenience, and prices at the local trading post--which had had excessively high prices and refused to cash welfare checks except for credit--were lowered.

Mr. Bjork The Oklahoma City Area mental health, social services, and alcoholism staffs are combined into a Human Services Branch. Mental health and social services were merged in 1976; alcoholism was added in 1978-1979.

At the Service Units, there have been a number of staffing changes since 1974, partly as a result of Indian staff members' assuming more advanced positions after training or after receiving credentials in formal educational programs.

Mr. Williams The growth that has occurred over the years in the IHS Mental Health Program is a testimony to the needs and to its accomplishments. Active liaison with NIMH was renewed most recently in 1977 under Secretary Califano's Indian Initiative. The two organizations also coordinated in connection with the Community Mental Health Center Program and the "Most In Need" program, which assisted seriously mentally ill children, among others.

In the late 1970s, staff from NIMH and IHS worked intensively to plan for shaping and then implementing the Mental Health Systems Act with reference to special provisions for participation by tribes. Although the Act was never implemented because of the decision in 1981 to fund mental health activities through block grants to the States, it outlines some ways in which the Federal Government might interact today with Indian tribes or with urban Indian organizations. (Some of the provisions are reflected in the Alcoholism, Drug Abuse, and Mental Health Services Block Grant and other PHS block grants.)

Areas of NIMH operations that seem promising for future cooperation include research, research training, and professional collaboration in other areas of mutual interest. Some funding to institutions and to individuals is benefiting Indians now through the research training program.

(Due to time constraints, no group discussion was held.)

Discussion III

Services for Children and Adolescents

Moderator: Johanna G. Clevenger

Presentors: John B. Thomas
Roland Johnson
David Heppel
Raymond B. Butler

Dr. Clevenger There are several key dimensions in treating adolescents:

(1) School problems and performance -- These include increasing the levels of functioning and teaching the ability to learn by solving problems.

(2) Bonding -- Indian adolescents often come from disruptive backgrounds, such as foster care or boarding school, in which they did not experience secure, supportive relationships with adults.

(3) Alcohol and/or drug abuse -- Physical and psychological aspects of alcohol and drug problems must be dealt with effectively as part of treatment.

(4) Impact on the holding situation -- Mortality goes up dramatically among family members during a 10-year period where there is an acting-out adolescent.

Dr. Thomas Serious emotional disturbance in Indian children exists in relative numbers equal to or greater than in the general U.S. population. This is shown in greater-than-average rates of suicide in adolescents, high incidence of child abuse in those areas where this has been studied, and high rates of serious substance abuse (especially alcohol, and gasoline sniffing).

These disturbances do not suddenly develop in adolescence from pre-pubertal emotionally healthy children. The grade schools also have high numbers of seriously disturbed children, but the hidden depression and less extreme conduct problems do not strike the mind so sharply as the teenaged cases.

These seriously emotionally disturbed Indian children, and their families, need and have a right to evaluation and treatment at a level of service comparable to the rest of the country's mainly public mental health services to children. These include outpatient child guidance clinic services to children and families, as the appropriate basic treatment for most of the cases.

Personnel needed for such a service include the following types and staff composition for each team: one child psychiatrist, one clinical psychologist, four psychiatric social workers, and eight mental health technicians.

The provision of such clinical services is not the only approach necessary, of course; social, economic, and creative preventive approaches are also vitally important. But it is absolutely true that one of the best and most useful things people have slowly learned to do over the ages is to provide relief, help and treatment, case by case by case.

One-fourth of all the inpatients on the psychiatric service at Gallup are adolescents between the ages of 13 and 18. Most of these adolescents are girls and the reason for this is not clear. It does appear that referral agencies respond more quickly to serious suicide attempts of adolescent girls than they do to the perhaps less clear depression of adolescent boys. The proportion of psychotic adolescents requiring inpatient service at Gallup is the same for boys and girls.

Mr. Johnson In FY 1980, there was a Congressional mandate for BIA and IHS jointly to spend $300,000 in connection with handicapped Indian children. The two Bureaus developed a Memorandum of Agreement to carry out a study to determine (1) whether it was possible for IHS and BIA to operate a joint program of services for handicapped children, and (2) whether there was a need for the diagnostic and treatment facility which was then recommended by tribal groups and IHS. A contract for the study was awarded to the All Indian Pueblo Council.

The study led to the establishment of the joint Indian Children's Program (ICP). The ICP subsequently contracted with the University of New Mexico School of Medicine for specialized diagnostic services.

ICP became involved in a number of other projects, including research and preventive activities relating to fetal alcohol syndrome (FAS). This effort was begun in response to the International Year of the Child.

ICP has also undertaken a study of epilepsy among selected tribal groups, including case finding and treatment. Another research effort is the Study of Multicultural Pluralistic Assessment (SOMPA), designed to examine the practicality of establishing culturally-oriented psychological testing norms. This work was carried out on the Laguna Reservation and in the Zuni Pueblo.

Current opportunities for cooperation between BIA and IHS are not being pursued as often as they should be. For example, BIA hires diagnostic personnel when it would appear that they could refer children to IHS personnel located nearby.

The issue of the proposed residential facility should continue to be explored, despite the lack of resources.

Dr. Heppel Children's needs tend to be overshadowed by those of adults, who always seem to receive more staff time if children and adults are served in the same treatment program. Children require a variety of services from several disciplines. These patients also need a specialized focus because they tend to be neglected. Children, for example, should be maintained in the most therapeutic, most normalizing, or "least restrictive" environment. Where prevention efforts can work, they are of greatest benefit to children. IHS should consider how to allocate more staff to deal only with children.

There are a number of problems concerning services for Indian children:

(1) The discrepancy between needs and resources. The difference between promise (legislative authorization) and reality (appropriations) is profound. A residential facility would be valuable because of the capacity it would provide for treatment and other activities that cannot be done on an outpatient basis.

(2) The shared responsibility for serving children. There are typically several agencies involved, a situation which frequently leads to turf squabbles and to professional bickering and parochialism. At the same time, these cross-cutting needs encourage cooperation.

(3) Priority setting for children's services. This can be a dilemma in terms of a public health model. For example, hearing aids and eyeglasses tend to be given low priority relative to urgent and emergent medical conditions in the provision of contract health services in some Areas.

(4) The impact on BIA of changing IHS priorities. When assumptions about services by one among a number of interrelated agencies turn out not to be valid, gaps in services or funding problems for other participating agencies are likely to result.

(5) The question of where the developmentally disabled fall. The Office of Mental Health Programs has defined "mental health" in the broadest terms. This definition encompasses the developmentally disabled, but the Mental Health Program has insufficient resources to serve them. On the other hand, the Program has been held accountable, perhaps inappropriately, for this group.

(6) The question of whether the ICP should be considered a regional or a national program. Eighty percent of the current services are carried out regionally. The other 20 percent of the work doesn't begin to meet the needs, except in the Albuquerque and Navajo Areas. Where these resources should be focused is both a management and a policy decision.

Mr. Butler BIA has a $98 million social services program this year, and has just received permission to seek a supplemental appropriation of $7.4 million. Of this amount, $15 million is designated for child welfare services, of which 60 percent is under contract to tribes (under the 638 contracting authority).

The Indian Child Welfare Act of 1978 is a landmark piece of legislation. Title I, covering legal, judicial, and administrative placement requirements, is having a marked, positive impact on both the Indian and non-Indian juvenile justice systems. Title II, covering services, appears to have resulted in a substantial drop (of over 400 cases) in average cases per month in the child welfare program. During FY 1983, BIA awarded 152 grants for services, including 26 to off-reservation organizations.

Discussions between BIA and IHS began in 1977 on an interagency agreement to address diagnosis, prevention, community services, and residential treatment of adults and children. The agreement spelled out the respective responsibilities of the agencies and specified a formula for sharing costs. The agreement, which was signed in the fall of 1979, was viewed as a starting document.

A review in December, 1980, showed that some Areas had participated actively and that 19 children who were seriously disturbed had been sent for residential diagnosis. The agreement was then extended for purposes of revision. Agreement as to revisions was never reached, however, because of unresolved differences between BIA and IHS. In April, 1983, Dr. Rhoades cancelled the agreement because of the unresolved funding problems. (It should be noted, however, that the two Bureaus are serving children jointly in the Phoenix Area, and perhaps in other Areas.)

The dialogue should be reopened, since the cost factors have overshadowed the real purpose of the agreement: to fulfill mutual responsibilities to Indian children in a more effective manner.

Comments from the Group Discussion Individual comments suggested a need for more child psychiatrists and residential facilities, though this was not the position taken by the panel members.

The emphasis should be on preventive, rather than curative services, although there is a need to maintain a spectrum of services. There will never be enough money or facilities or child psychiatrists. It is specious to imply to Indian communities that by treating individuals the causes of mental disorders are being addressed.

The group should spend some time defining the problem which the Mental Health Program is to address.

There are arguments for maintaining some inpatient units. They can help by providing an appropriate setting for thorough evaluation and treatment of the most severely disturbed children and to answer such questions as: What is "continuity of care" for these patients? What are the best initial steps? Such units also provide a base for multiple operations, training, and outreach.

For example, a statewide survey indicated that there are about 250 violent and severely mentally ill youngsters of all races in New Mexico. A state-financed 36-bed hospital for them has been proposed, although such a facility would be very expensive to build and operate. On the other hand, experience has shown that if such youngsters are not treated properly, they will cost the taxpayers about $0.5 million each in prison stays, welfare payments, etc. The success rate in Colorado* with this type of treatment, which is an example of secondary prevention, is approximately 70 percent.

*This is a reference to the Compulsory Adolescent Treatment Center in Denver. The project is directed by Dr. Vicky Agee, and is under the aegis of the Colorado Department of Corrections.

There should be opportunities for Indian youth to renew their traditional and spiritual connections.

Discussion IV

Evaluation and Research Findings; Needs for Evaluation and Reporting Systems

Moderator: Robert A. Walkington

Presenters: William Richards
Morton Beiser
Spero M. Manson
Joseph D. Bloom
William Douglas

Mr. Walkington The background materials reflect four themes relating to this panel: (1) little program evaluation has been done, although there has been a marked increase in research; (2) usable data on program outputs are highly limited; (3) there is great variability in programs, and specific objectives are lacking in a number of cases; and (4) there is a call for more evaluation of Indian mental health activities.

Spero Manson has said, in "Mental Health Services to American Indian and Alaska Native Communities":

> Evaluation examines specific organization and service delivery goals in the context of community needs and subsequent impact. Planners and administrators of Indian programs advocate evaluation of this nature but seldom practice it. In those few instances in which such efforts are carried out, program response (in the form of modification or redirection) rarely follows.*

Such a lack of modifications is, of course, not limited to Indian programs.

Dr. Richards Eight points reflected in the background book are pertinent here:

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*Manson, Spero M., and Trimble, Joseph E., "Mental Health Services to American Indian and Alaska Native Communities: Past Efforts, Future Inquiries." In L. Snowden (Ed.), Reaching the Underserved: Mental Health Needs of Neglected Populations. Beverly Hills, Ca.: Sage Publications, 1982.

(1) There are no formal program standards. Headquarters staff should develop standards for use in establishing and monitoring 638 contracts, and for general use in the Mental Health Program.

(2) There are general problems in evaluating psychotherapy, which are not unique to IHS. However, these differences -- which frequently involve valid differences in perspective -- should not preclude IHS from undertaking needed studies.

(3) There has been no action on most of the Beiser-Attneave recommendations. These should be reviewed and action taken, as appropriate.

(4) There have been no Headquarters management reviews of Area programs since 1981. Such reviews should occur regularly, should be based on program standards, and should influence future funding.

(5) There are no research dollars in IHS for mental health except a small amount for work concerning biofeedback. Research in the area of mental health of Indian people should be increased.*

(6) Proven models haven't been adopted in the rest of the program.

(7) The data system is obsolete. In its current form, the system requires lots of paperwork and produces very little usable information.

(8) Efforts to revise the data system have been hampered by lack of (a) an OMHP policy and procedures manual, (b) 638 contract review procedures, and (c) program management review procedures.

Dr. Beiser In 1973, IHS let a contract for a baseline study describing the early Area mental health programs. Among the findings were positive features such as the use of native

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*The IHS clinical research program provides limited funds to support research by IHS personnel concerning topics that are of interest to them and of potential benefit to IHS. It is not program-directed research support in the sense of research funded by the National Institutes of Health, for example.

healers and the model dorm at Toyei.* The study also found that a number of services needed to be developed for special populations, including children and boarding school youth, children with hearing loss and deafness, the elderly, the chronically mentally ill, and the mentally retarded.

A small contract was issued by IHS in 1974 to examine staff and patient characteristics, including presenting problems. The study found an inverse relationship between the amount of time people spent in doing prevention and the level of training they had achieved: those with the least training spent the most time doing preventive activities.**

There is a need to continue evaluating the Mental Health Program and to encourage more epidemiological work. Results of new evaluations would be valuable for program planning and for assisting practitioners.

A slide concerning treated prevalence in 1974 compared trends among IHS clients to national treatment data. After age 9, the rates of mental illness for Indians climb dramatically, though this isn't true for non-Indian children. Indian children also start doing poorly in school at age 9. By mid-adolescence, Indian boys come into the mental health treatment system at a rate 4.5 times that of non-Indian boys; Indian girls come at a rate 5 times higher. There is a need for further research to determine why this effect occurs, and why age 9 seems to usher in a period of risk for Indian children.***

Dr. Manson A review of current studies supported financially or logistically by IHS shows a relationship to work conducted in the 1970s. These studies can be grouped into four substantive areas:

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*Beiser, M., and Attneave, C. L., "Mental Health Services for American Indians: Neither Feast Nor Famine," Journal of the White Cloud Indian Research and Development Center, 1 (2): 3-10, 1978. Reprinted in Dana, Richard W. (Ed.). Human Services for Cultural Minorities, Baltimore, University Park Press, 27-41, 1981.

**Beiser, M., and Attneave, C. L., "Analysis of Patient and Staff Characteristics, Presenting Problems and Attitudes Toward Mental Health: IHS, Mental Health and Social Services," Report in fulfillment of contract 240-75-0001, Indian Health Service, 1977.

***Dr. Beiser is conducting current research, supported in part by NIMH, that should provide some new information concerning this question. See page 22. Also see Beiser, M., and Attneave, C. L., "Mental Disorders Among American Indian and Alaska Native Children: Rates and Risk Periods for Entering Treatment," American Journal of Psychiatry, 139 (2): 193-198, 1982.

Diagnostic Techniques

- Study of Multicultural Pluralistic Assessment**--is carried out through the Indian Children's Program.

- American Indian Depression Study**--grew out of brainstorming based on Volume 2, Number 2 of the Journal of the White Cloud Center. This has led to further work supported by NIMH. Shore and Manson are continuing to examine the potential interface between indigenous expressions of psychopathology and the Western diagnostic criteria.

- Somatization and alcohol-related behaviors--work is continuing and there is potential for extension to other areas.

Epidemiology

- Dr. Jerrold Levy's work concerning convulsive disorders in Southwestern tribes**--has resulted in a case registry.

- Dr. Levy's study among the Hopi**--concerns the epidemiology of a variety of social pathologies.

- A study by Adding, Bouvais, et al.--concerns drug abuse.

- The Flower of Two Soils--deals with the Indian child. This project, by Beiser and others, is a longitudinal assessment of second and fourth graders in reservation and urban settings in the United States and Canada. This is the project in which the "crossover" effect is being studied. It is a model for the type of research that needs to be done in Indian mental health.

Treatment System Evaluation

- Competencies of community health representatives**--is being carried out by Douglas, Neligh, and Bonifield to determine standards for delivery of mental health services.

- Study of civil commitment patterns--is being done by Bloom, Neligh, and Rogers, as described below.

**A double asterisk indicates that IHS funded the study, either fully or in part.

Prevention

- o Fetal alcohol syndrome projects**--An epidemiological study has been completed, showing wide variations in incidence across tribes. Current funding, from the Office of Alcohol Programs, supports a preventive effort to train people who will, in turn, train others across the country. The director is Philip May. (The project is both directly and indirectly supported by OMHP.)

- o Conference on prevention in Indian communities--led to a report entitled "New Directions in Prevention in American Indian and Alaska Native Communities" which includes 24 recommendations for future research.

- o Conference in October, 1984--Oregon Health Sciences University (OHSU) will hold a conference of research scientists to discuss a research agenda on Indian health. The meeting will include debate about the relevance of a National Academy of Sciences document that outlines a research agenda on prevention but does not mention minorities.

- o Relationship between physical illness and depression--OHSU began a new study in February to examine this relationship among Indians.

Dr. Bloom NIMH issued a three-year grant ending in 1983 to study civil commitment; the group, led by Dr. Bloom, is now writing up its findings. The project was inspired by a case on the Warm Springs (Oregon) reservation, in which a young man was convicted of first degree murder. His medical records show clearly that for several months prior to the murder, the man's mental condition was deteriorating and his propensity for violent behavior was increasing. It was clear to IHS people working with him at the time that he should be hospitalized, but his reservation lacked procedures for civil commitment. The staff were unable to get him into a voluntary hospital. The study was conducted on six reservations: two in the Billings Area, two in the Portland Area, and two in the southwest, including the Navajo Area.

A tribal code providing constitutionally-guaranteed review processes is crucial to treating patients such as the Warm Springs man and protecting other community residents. Development and operation of such codes require cooperation between IHS, tribal mental health programs, tribal governments, and States. As part of developing appropriate civil commitment

practices, the role of IHS facilities and staff vis-a-vis the State must be clarified.*

Performance of the field work was complicated by the frequent, abrupt changes in tribal officials, such that continuity of knowledge about the study was broken and permission to continue had to be resought in some locations.

The findings suggest some fundamental questions:

1. Should IHS deal with the most serious psychiatric emergencies?

2. Should IHS provide consultation to the criminal justice system?

3. Should IHS provide inpatient facilities on the larger reservations for both voluntary and involuntary patients? (The Navajo badly need such a service. The Gallup unit is a vital part of the system, but it is off reservation.)

4. Should IHS take a more active role in developing a network of services between the tribe and the State, to make sure that severely ill people are neither criminalized nor untreated? (IHS should take a position on this.)

5. Should IHS divert resources to help develop such networks?

Dr. Douglas The current mental health and social service data system, which is the only source for all Areas except Billings and Alaska, presents workload data only. The Patient Care Information System (PCIS), available in those two Areas (and in the Tucson Program Office), is designed to support Service Unit operations and does not work well when one tries to aggregate data at higher organizational levels.

A report prepared by NIMH** deals with the key elements of a good mental health statistics system. With suggestions from the Branch Chiefs, this design could serve as guidelines for a

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*Manson, Spero M., Bloom, Joseph D., Rogers, Jeffrey L., and Neligh, Gordon, "Emerging Tribal Models for the Civil Commitment of American Indians." This work was supported by NIMH grant 5R01 MH35209.

**National Institute of Mental Health, Series FN No. 8, The Design and Content of a National Mental Health Statistics System. Patton, R.E. and Leginski, W.A. DHHS Pub. No. (ADM) 83. 1095. Rockville, Maryland: The Institute, 1983.

desirable mental health data system. In considering use of microcomputers in connection with mental health data, one should review the Veteran's Administration experience. The VA is using a programming language, MUMPS (Massachusetts General Hospital Utility Multi-Programming System), that is adept at manipulating medical records.

The design for a new mental health system should be capable of linking workload, patient care, and cost data. Also in relation to cost data, OMHP has participated in a 1980 WICHE (Western Interstate Commission on Higher Education) study of mental health manpower in 10 Western States. The results reflect information on staffing, workload, and distribution of tasks. Along with improved cost data from a new mental health system, OMHP should be able to use the WICHE data as a baseline for re-examining the Resource Allocation Criteria for the program.

Comments from the Group Discussion The Navajo tribe has established a task force to assess what to do about violently mentally ill persons. This tribe is likely to ask IHS to hold such patients in non-psychiatric beds in IHS hospitals as a way of protecting the patient and the community while longer-term arrangements are made. Dr. Rhoades' response: "We would need to seek a legal opinion, but I suspect it may be illegal for IHS to hold patients involuntarily." (Patients can be held involuntarily in Alaska where the tribe has contracted under 638 authority to operate the facility, and where the State has designated it as a commitment facility.)

A comprehensive mental health program designed to serve Indian people must include appropriate procedures for dealing with civil commitment.

It is certainly ideal to handle cases involving civil commitment on the basis of what seems best for the patient. But often the persons who must make initial decisions about such cases are mental health technicians who may feel considerably less confident about the choices than would a psychiatrist. IHS needs clear clinical lines of authority to assure and support appropriate clinical decisions at all levels of the system.

Very little Indian health research has addressed the interface of mental health, alcoholism, and physical health services. The separation of these topics may limit the usefulness of the results, since individual patients are likely to exhibit symptoms in all three categories. The lack of crosscutting studies may reflect the organizational separation.

Dr. Brandt has asked NIMH to suggest some ideas for research cutting across these areas. This research has not yet been budgeted, however.

IHS should consider developing a more effective way to inform researchers of activities and findings, to minimize the number of times someone "reinvents the wheel."*

*Ways to disseminate information about research supported by IHS are currently being examined. One possibility is to announce research projects in The Primary Care Provider, a monthly IHS publication.

Discussion V

Organization and Funding

Moderator: Jack Ellis

Presenters: James D. Felsen
George Blue Spruce
Edward Kruger
Margene V. Tower
Gordon L. Neligh
Michael P. Biernoff

Dr. Ellis This panel will deal with perspectives and multiple answers rather than "objective facts," as presented on the first day. In the mental health field, there are multiple hypotheses, all of which seem worth retaining.

The Venn diagram below (from the NIMH statistics report, referenced earlier), shows the mental health system partly inside and partly outside the health system.

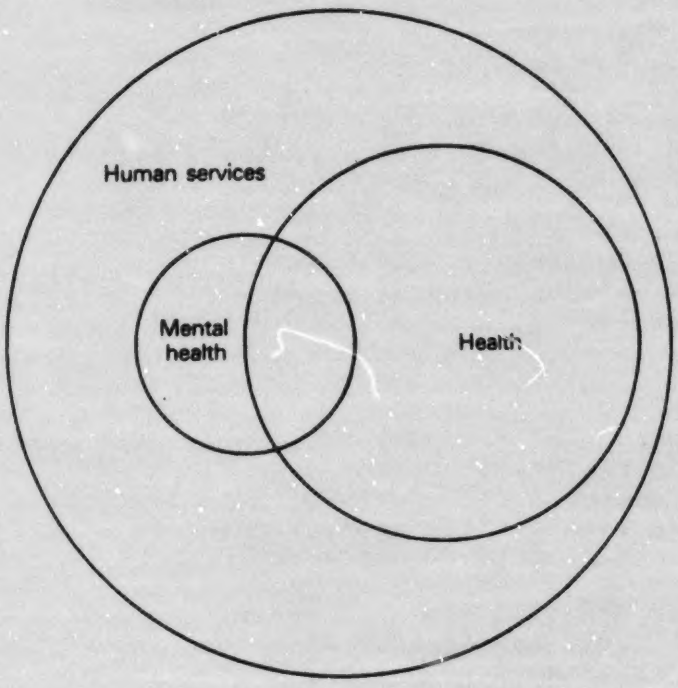

Figure 3-1. Relationship between health and mental health services as a part of the human services domain

Dr. Felsen In its earliest years, the Mental Health Program addressed the most serious areas of morbidity and mortality. It was also faced with organizational rigidity, insensitivity, and negative bias toward mental health services. The program was established to advocate for mental health as a categorical focus. As the program matured, however, concern was voiced as to how to expand the effectiveness of mental health. Program officials began to realize that needed resources were controlled by line managers, but that tapping these resources would lead to relinquishment of the advocacy role and diminution of control of categorical dollars.

Originally, the Mental Health Program reported to the Headquarters Division of Resource Coordination; four or five years ago, the program was shifted to the Division of Program Operations. Now, it officially relates to the line managers.

It isn't clear what the organizational focus of the Mental Health Program should be; however, several roles at Headquarters have to be balanced:

(1) Advocacy up the line to the Congress -- presentation of unmet needs, in order to secure resources;

(2) Program balance -- assuring internal management stability;

(3) Advocacy within the IHS for special programs; and

(4) Provision of the most effective and efficient allocation of resources.

The majority of people who have contact with people with mental health problems are the "local warriors." Mental health people will have to give up some autonomy to gain full acceptance and integration. Integration, however, would facilitate wider dissemination of new clinical advances in the treatment of mental disturbances.

Dr. Blue Spruce The Area Director needs more authority and flexibility. It's extremely difficult to hire and fire people, and the multiple categorical budgets greatly restrict one's ability to get the most for the money, since funds can't be transferred from one program to another.

In the Phoenix organization, the Mental Health Program derives support through cooperation with the rest of the IHS and from community arrangements. However, accomplishment of the job requires sufficient resources.

Mr. Kruger In the Ada Service Unit, mental health, social services, and alcoholism are combined into one branch headed by a Coordinator of Human Services. Staff tend to act as generalists, blurring the distinction across disciplines. The Coordinator is the direct line manager for all of the IHS field health programs, including the sanitarian's activities and public health nursing. He is also the project officer for the tribally-operated alcoholism program. Close cooperation is required for the staff to function effectively in this structure.

The Coordinator and the Area Mental Health Branch Chief jointly set program (clinical) standards; line officials provide administrative support. The two groups work together to plan program changes and set priorities.

Benefits of the model include:

1) Human services programs are well integrated with the others.

2) Human services staffs are well positioned to provide liaison between the hospital programs and the tribal programs -- and ultimately to the patient.

3) The small staffs lend themselves to this organizational approach.

4) Integration of staff meshes well with the typical, multi-problem patient. This helps to reduce any tendency toward "your patient, my patient" controversies.

5) The cooperative spirit and small size of the staff tend to discourage empire building and keep the focus on the patient.

There are, of course, disadvantages as well:

1) There is little room to accommodate personality clashes.

2) Since each staff member has two bosses, the supervisors must make sure that all assignments are clear.

3) The lumping of programs leads to questions of fairness in allocation of resources. (This arrangement doesn't necessarily mean fewer dollars for mental health, however; in the Ada Service Unit, line managers have taken funds from other sources to add four positions to the three that were allocated from the Mental Health budget.)

Ms. Tower The Billings Area Branch is organized according to a systems model, which has become less fuzzy and more complex with time. The underlying concept is that services and staffing must be relevant to the Indian cultures in the area, and based on the latest technology that can be transmitted to the Service Units.

The initial step was to gather data on the nature of disease patterns. To facilitate this research, the Billings staff argued for implementation of the PCIS system . (PCIS has not worked well for administrative or workload data, but it uses a standard nomenclature, which is important for linking PCIS data with other systems.) A summary of 1983 contacts, based on first and second diagnoses, shows 17,000 contacts, of which 2,300 were for referrals to other sources of service and coordination with other agencies on behalf of patients.

The Billings program places considerable emphasis on training in diagnosis and treatment of affective disorders. For example, the staff are becoming quite sophisticated in knowledge of psychopharmacologic drugs, and in the neurochemical and organic bases of mental disorders.

The sizeable proportion of V codes in the DSM-3 diagnostic categories argues for the kind of integrated organizational structure used in Oklahoma City and Portland. In Billings, program lines are blurred, but there are technological expectations for each staff member.

The Billings model has five axes:

1) Administration - for controlling, planning, and coordinating functions;

2) Program components - for defining required program services, e.g., adult outpatient and inpatient psychiatric care;

3) Treatment modalities - for determining the types needed over-all in the Area (though no one person can provide all modalities);

4) Patient needs - for assessing utilization and prevalence data in relation to expectations (based on epidemiological data); and

5) Data and information - for assessing coordination between various Service Units and determining whether data are flowing as they should.

The model also serves as a basis for developing performance standards for staff members, in that standards are tied to operational program goals.

The Billings budget process also contributes to integration of services planning, in that all line managers and program directors have an opportunity to argue their case with their peers and superiors.

Dr. Neligh It has been valuable to have epidemiological data for program planning. The comparison of utilization data and epidemiological data shows that the Billings Area is underserving some populations: children, schizophrenics, people with panic disorders, the chronically mentally ill, and persons with somatoform disorders.

The Billings staff have tried to use technologies rather than administrative structures to deal with organizational boundaries. For instance, case management technologies are used to interface with the social services program.

An expectation of substantial reimbursement by Medicaid and Medicare is unrealistic, based on experience in Billings, because psychiatrists and psychologists are the only professionals whose services (as individuals) are eligible. The Mental Health Program depends heavily on mental health technicians, psychiatric social workers, and nurse practitioners. It is also unrealistic to assume that private insurance coverage is extensive for mental health services. In Billings, only some non-Indian professionals have such insurance.

Dr. Biernoff In a service delivery system, organization cannot be separated from the type of service provided, who provides it, the appropriateness of the service, the quality of the service, and the manner in which it is provided. This interrelationship can be expressed as a series of dichotomies:

1) Community base vs. a hospital base for the program; medical vs. non-medical model

2) Direct vs. indirect services; treatment vs. prevention orientation

3) Crisis intervention vs. chronic care; short-term vs. long term care services

4) Individual vs. family; adult vs. child

5) Clinical supervision vs. more autonomous functioning

With respect to #5, the Mental Health Program does not have the level or intensity of clinical supervision to help all staff function at or near an optimal level. Mental health technicians bear a tremendous burden, and suffer burnout as a consequence.

The impact of organization on administration suggests several questions:

1) Where does Mental Health fit into the over-all Service Unit organization?

   The Mental Health Program can be functionally isolated because of its differences from a medical model. It's almost as if the rest of the system had given up responsibility for dealing with mental health issues.

2) At the Area level, should mental health, alcoholism, and social services be combined?

   There are some disadvantages to this as well as advantages.

3) At the Headquarters level, should the Office of Mental Health Programs be moved to Rockville to provide more access to the Director of IHS?

4) How can organizational rigidity best be overcome?

   Organizations are often resistant to change, even when change may be appropriate, e.g., the current poor data system for mental health.

The organizational structure should be based on service needs that have been established.

Comments from the Group Discussion Technical solutions should be tested as a solution to problems. Some approaches being used elsewhere -- for example, to ensure continuity of care -- should be tested in the Mental Health Program.

It is frequently the line administrator (as opposed to the program director) who has worked for integration of services. Some experience suggests, however, that line managers cause unnecessary conflicts because of an inappropriate desire to control the resources and details of line-item programs.

There isn't necessarily a conflict between using technical solutions and changing organizational structures.

Mental Health staff should set limits for the program; otherwise, the line administrators will do it.

Most front-line clinic staff aren't trained to recognize mental health symptoms. The resources of the rest of the system need to be tapped for mental health needs in ways that will expand the capacity for approriate service. From the perspective of mental health staff, staff in the rest of the IHS system should consider a more holistic approach, which has long been integral to the Mental Health Program.

The drop of nearly one-third, from 285 to 200 positions assigned to the Mental Health Program, belies the view that Mental Health is a favored program. The reasons for this decrease in positions need to be clarified.

In thinking about organizational changes, one should consider three guiding principles:

1) Focus on services and standards of care for the major problems.

2) Integrate mental health, general health services, alcoholism, and social services.

3) Maintain professional identity with a particular program (as opposed to identity as a "human services" person). This is important for maintaining morale and commitment.

It is important to maintain the autonomy of the Mental Health Program while lessening undesirable distance from the rest of the organization. It must also be recognized, however, that there are some things the Mental Health Program cannot do because of resource limitations. This may mean changing the service delivery system.

Many Billings patients present with physical as well as mental symptoms. This fact indicates a need to do a literature review of the cost effectiveness of a consultation/liaison model (which the American Psychiatric Association is urging), as opposed to organizational merger. An article in the American Journal of Public Health summarizes benefits of the consultation model in relation to reductions in length of stay and other indices.*

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*Mumford, Emily, Schlesinger, Herbert J., and Glass, Gene V., "The Effects of Psychological Intervention on Recovery From Surgery and Heart Attacks: An Analysis of the Literature," American Journal of Public Health 72 (2): 141-151, 1982.

Lines of convergence of mental health with non-mental health staff occur primarily in connection with patients who have chronic physical illness, such as diabetes or Alzheimer's Disease. The literature shows that 60 percent of those patients diagnosed as having Alzheimer's Disease may have a reversible organic brain syndrome. With such cases, the importance of a consultation model among mental health and non-mental health staff becomes clear.

It is important to prevent circumstances in which lack of articulation of mental health services with other clinical services impedes interaction with other components of care, to the detriment of the patient. In an environment of multiple authorities and sometimes unexpected budget cuts, when survival tends to become the main interest, one cannot expect consistent cooperation and focus on patient needs. IHS needs to develop ways to integrate mental health services and other clinical services in a supportive and flexible way.

The physical separation of the Office of Mental Health Programs from the Director of IHS raises a question as to whether OMHP should be moved to Headquarters East. If the national director of Mental Health were located there, he or she could take a more active role in discussions of budgets and fund allocation. The director might also be better able to lead the development of a national data system for mental health and coordinate it with other IHS data systems. There are advantages to a program director that derive from being able to meet frequently with the Director of IHS. The "squeaking wheel" does get more attention -- though that attention doesn't necessarily translate into dollars that wouldn't otherwise be allocated to the program. Several participants advocated moving OMHP to Headquarters East.

There is a significant movement that is taking IHS from a direct service to a health care financing organization. It is the interface with patients and the community that has been emphasized so well here. The question is: How can IHS carry out a growing health care financing function and still maintain the magic that exists in the field?

It is true that positions and dollars allocated to the Mental Health Program have been shifted to other uses by Service Unit or Area Directors. This has occurred in some instances because of over-all fund shortages. In some cases, the cost of retaining an individual has risen as a technician moves up to a higher level following training.

It's not clear that Mental Health has been cut to a greater extent than other programs. Nor should every program have a Washington advocacy office. Once a program gets beyond its initial, special emphasis focus, it should be closely integrated with the rest of the IHS services.

Discussion VI

Contracting Under PL 93-638

Moderator: Ronald H. Carlson

Presenters: Roland Johnson
William Richards
C. Stanley Stitt, Jr.
Richard Winslow

Mr. Carlson The purpose of this panel is to discuss trends in 638 contracting and lessons learned, particularly in relation to mental health services. Standards for hiring and for clinical services, and the role of mental health staff in individual contracts are of special interest in the mental health context.

Dr. Stitt Based on a survey of Chief Medical Officers and Mental Health Branch Chiefs, there are two major problems with 638 contracts: (1) lack of standards in hiring of staff and (2) lack of treatment standards. The quality of a local program is heavily dependent on the person who directs it.

It should be noted that tribes are currently hiring competent people to direct their mental health programs. (The initial IHS reliance on paraprofessionals in its own direct services may have given tribes the wrong signals about expectations for hiring professionals versus nonprofessionals to direct and provide services in their mental health programs.) It is also important to remember that IHS serves sick communities as well as sick individuals, and the sickness of communities often has greater impact on program operations than the sum of the people within them who have mental abnormalities. One symptom of community mental illness is behavior that guarantees that the tenure of any competent mental health director will be short. Consequently, there is a frequent turnover of directors in these locations and program quality suffers. In addition, IHS has tended to call people newly hired off the street "paraprofessionals," although this term is supposed to imply some training and experience. Fortunately, this is happening less often now.

The 638 process itself, because of the way it has been interpreted, may tend to foster the isolation of the Mental Health Program from the other IHS services at the Area level, though this result shouldn't necessarily occur. Independence can

be overemphasized to the detriment of the program. Furthermore, the normal Federal procurement process is not an appropriate instrument to promote a working relationship between two groups that have a common interest in providing services to people who desperately need them. The law provides only two valid reasons for IHS to cancel a contract: (1) performance in a manner that threatens human health and safety, and (2) gross mismanagement of funds. The presence of these conditions is difficult to prove and IHS is unable to cancel contracts in those rare instances where cancellation would seem to be in the public interest. This situation prevents IHS from re-allocating funds to other locations where they might better be used. The General Counsel opinion requiring IHS to carry over unused funds from one contract year to the next also can lead to situations in which a tribe holds funds that they are unable to use, and in which IHS is prevented from giving the funds to other tribes.

Mr. Johnson The 638 legislation was designed to strengthen tribal self-government. However, current procurement procedures of BIA and IHS create a serious hindrance to realizing the intent of PL 94-638. There is no question that the law is a desirable one or that tribes are sincerely interested in learning to administer IHS and BIA programs, although there are problems to overcome in enabling tribes to take over some programs. Tribal officials must understand the responsibilities inherent in contracting for programs, and Federal managers must remember that they retain the responsibility to assure that the Indian people continue to receive quality services.

IHS and BIA 638 policies and procedures differ in a number of respects. It would be helpful to tribes, who must deal with both entities, if these policies and procedures were made uniform. In fact, the underlying policy with respect to the Federal role differs: IHS informs tribes of their option to contract and offers technical assistance in making the decision. BIA, on the other hand, requires its field officials actively to encourage tribes to contract. Other problems with the 638 process are (1) the inappropriate assumption of decision making in programmatic areas by some procurement offices, when decisions of these types should rest with program officials, and (2) failure of the Federal entities to audit all closed-out contracts promptly. In addition, the dual BIA roles of advocacy and oversight of 638 contracts lead to conflicts of interest.

At the same time, 638 contracts have yielded a number of significant benefits:

1) They have greatly increased the level of services to some tribes (e.g., Laguna).

2) They have helped tribes to strengthen their management capacity.

3) They have enhanced relationships between the tribes and the Federal entities.

While many problems remain, one should note that 638 contracting has forced tribes and the Federal government into a series of fruitful partnerships that otherwise wouldn't exist. Paradoxically, the decreased budgets in recent years have also fostered close working relationships in the effort to maintain at least the established level of services.

Dr. Richards There are multiple people with different roles in 638 contracting (e.g., finance, personnel) who want more structured guidance. Standards should be based on the nature of the job to be done. For example, an entirely different type of person is needed to treat developmental disabilities than to do primary care in a village. There are not enough trained Native people who could be hired by IHS to deliver clinical services.

It is more expensive for IHS to fund services through contracts than to deliver them directly, because of the tribal indirect cost rates (which may be as much as 40 percent in Alaska). In some cases, IHS is not able to include funds for these indirect costs in the 638 contract; consequently, program dollars may have to be used to cover these costs. Under these circumstances, the amount of services is reduced unless the tribe can obtain alternate resources.

Contracting seems to work best when a tribe contracts for an entire Service Unit, rather than for one or more individual programs. When a tribe takes over mental health only, there are typically problems in coordinating tribal and IHS personnel policies, such as those relating to hiring, performance appraisal, and grievance procedures.

Two types of action should be considered to strengthen 638 contracting in mental health:

1) Issue mental health review guidelines in final form, after the section on processes and assurances is tightened up.

2) Implement some of the Beiser/Attneave recommendations, including those concerning orientation of new personnel, recruitment of physicians for rural locations, and training and retention of paraprofessionals.

Dr Winslow Four of the leading causes of death among Indians are behaviorally-related. (These are accidents, suicide, homicide, and cirrhosis of the liver.) In some ways, the IHS commitment to dealing with these behaviorally-related causes of death is seriously

inadequate. A good mental health program needs quality people; good position descriptions that reflect local needs; staff who have had or are getting appropriate training; and good support and supervision. There are several obstacles to creating such programs in Alaska:

1) Mental health patients tend to be needy, and they don't typically advocate for good mental health care for themselves or their community.

2) There is a long history of racism. For example, adults can recall being beaten as children for speaking their Native language in school. In many places, the highest status people are white, whereas those with the lowest positions are Native. As a result, many 638 contractors view the clinical advice of non-Indian professionals with ambivalence or even hostility.

3) Federal and state affirmative action programs have often been more token than real. For example, sometimes a marginally qualified Native has been hired and allowed to fail. Then non-Natives and Natives say, "Natives can't do the job, after all." By contrast, a real affirmative action program would (a) launch an extensive and energetic search to find a qualified Native; (b) provide an expanded training program to locate promising Native high school students and assist them through a period of professional education, and (c) offer extensive training to marginally qualified people who have the intellectual and personal potential to become well qualified.

4) The role of mental health professionals in establishing 638 contracts is now only informal. Mental health staff should be involved in setting standards for services, should be contacted early in the contracting process, and clinicians should have a veto over the substance of the contract where clinical quality is an issue.

5) There are no written standards for mental health services. These should be developed as a tool for planning and monitoring these services.

6) There is a great deal that is not understood about these four causes of death. Additional research should be done about why these are so predominant among Indian people and what to do about them.

The assignment to reduce the incidence of suicide and homicide by 60 percent among Alaska Natives by 1990 is an overwhelming one.

Comments from the Group Discussion Dr. Rhoades asked how a given amount of funds for mental health should be divided between professional psychiatric services and mental health technician services. In response, there was a reference to a paper by Dr. Ward* of Canada which describes the preventive implications of a mental health program dealing with suicide and alcoholism. The paper describes the experience with a Canadian program for Indians, including:

1) How they conceptualized the problem of alcoholism;

2) How they used Indian ceremonies and social gatherings to reinforce abstinence from alcohol (no alcohol was allowed at their functions); and

3) How their outreach effort provided a way into the homes of alcoholics.

There are some successful interventions which need to be implemented widely -- not just tested again.

It's sometimes helpful to think of alcoholism as a chronic process. Programs for alcoholism and mental illness are sometimes viewed, inappropriately, as failures. In fact, programs for these diseases are just as successful as those dealing with other chronic illnesses, such as diabetes. In fact, the other six major causes of death are just as "mysterious" as the four that are behaviorally connected. There are some interventions that are both scientific and practical. Unfortunately, practitioners tend to fail to publish reports of successful results.

There are some approaches that can work. For example, several years ago in one community there was a rash of suicides among adolescents in the local jail. Subsequently, IHS staff arranged for adolescents who had been arrested to be held in another location. The suicides among this group were significantly reduced.

It is important to remember, however, that with population growth these four leading causes of death occur more frequently than they did ten years ago, even with no change in rates; that is, interventions must now confront problems of a greater magnitude.

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*The paper, in press, will appear in the Journal of Preventive Psychiatry.

Discussion VII

Rethinking the Mission and Future Direction of the IHS Mental Health Program

Moderator: William B. Hunter, III

This Discussion is summarized by topic, rather than in the sequence that the comments were made at the conference. As in earlier Discussions, the group did not attempt to reach a consensus in most areas. Here, as in all other sections of this report, comments represent the opinions of individuals, not necessarily fact or consensus (unless the text indicates a consensus).

Recommendations, comments that implied a recommendation, and statements indicating a need for action following the conference are underlined in the text.

As background for Discussion VII, Dr. Shore presented the following as a partial list of major accomplishments of the Mental Health Program:

1. Commitment to community involvement.

2. Indian involvement at the tribal level and in staffing IHS positions.

3. Emphasis on cultural issues, including traditional medicine.

4. Ongoing consideration for issues of prevention and services for children.

5. Balance of direct service, consultation, and prevention efforts.

6. Nationally outstanding model programs, for example, the Model Dorm Program at Toyei Boarding School.

7. Important contributions to the pool of mental health professionals with a commitment to public health.

8. Multi-disciplinary mental health teams at the Area and Service Unit levels.

9. A national reservation network for new direct mental health services that previously were unavailable.

10. Expanded IHS-university relationships for training, consultation, and research. These include, for example, the Universities of New Mexico, Washington, Oklahoma, and South Dakota, and the Oregon Health Sciences University.

Dr. Rhoades added an 11th accomplishment: the role of the mental health people in expanding awareness and understanding of mental health problems among Indian people, in addition to conducting the program in an outstanding fashion.

Scope and Mission of the Mental Health Program

During Discussion I (concerning mental health status), presenters and others noted major needs of Indians living in urban areas and suggested (1) more services for children and adolescents, (2) closer cooperation with alcoholism programs, and (3) research. These remarks were in the context of data from the Portland Urban Indian Program showing extensive health and socioeconomic problems, and a study of Indians living in Seattle. In addition, the need for further epidemiological data to use in prevention, treatment, and training had been reviewed.

In responding to presentations about organization and funding (Discussion V), participants noted the need for Mental Health officials to set limits on the objectives of the Mental Health Program in light of current and projected resources constraints.

The group endorsed community mental health as the model for the IHS program. They indicated that a national statement of mission should underlie the program to avoid the development of separate Area programs that differ to an undesirable extent and that such a national goal statement would be a useful product from the conference. The group unanimously endorsed the principles of the following statement:

> The Mental Health Program of Indian Health Service should be guided by a principle of developing model culturally-sensitive, comprehensive community mental health delivery systems with direct care, consultation/ liaison, and prevention. Direct care should include outpatient, crisis, inpatient, and other services. Consultation/liaison should include collaboration with Indian communities, education and training, and active

liaison with medical, alcohol, and social services. Prevention efforts should be directed at multiple levels with special attention to Indian children and adolescents.

Mental health staff will serve as advocates for improved mental health services for American Indian and Alaska Native peoples within Indian Health Service and with all appropriate Federal, state, and local resources. The program will facilitate evaluation and research to guide future developments.

There were significant concerns about the resources necessary to carry out this goal. Some stated that it would be impossible to maintain the current program or develop a model mental health program based on the current resource level because the existing program and budget are too small. It was pointed out that the IHS has always rationed care and what is needed in the Mental Health Program (as well as in other program areas) is an orderly way to ration this care. Some commented that if proper levels of mental health care are to be provided, real efforts must be made to increase resources. It is necessary to have an explicit assumption as to the level of anticipated resources in order to discuss future program direction in relation to particular populations or types of services. While the elements of a comprehensive program should always be available, IHS need not furnish all of them directly. One purpose of liaison is to leverage resources from other programs. The program will always be limited by resources; it cannot cure or stabilize every person. However, it can and should assure access to all.

There was also a conviction that the goal statement should not be applied as a check list for defining an "adequate" program at the Area or Service Unit level. Some services are not available in all communities and, consequently, the lack of resources may constrain the development of certain services by the IHS.

The group charged the Branch Chiefs to refine the goal statement and to develop an appropriate plan of action. There were suggestions both to develop a broad plan describing steps needed to make the Mental Health Program comprehensive and to develop specific plans regarding organizational accountability, standards, children and adolescents, the chronically mentally ill, and recruitment and retention. It was also noted that the IHS must determine the role of the Mental Health Program in prevention, research, direct services, financing, and advocacy both for reservation Indians and urban Indians.

Prevention: How Much and What Kinds

The group agreed that there must be a balance between prevention and treatment, that is, the Program should not stop offering all types of treatment, particularly for acute patients.

Among the types of prevention efforts suggested were ones designed to instill in Indian youths a sense of pride and power and a desire for competent performance. Such activities include:

1) Adventure-based recreation, which has worked well in some communities.

2) Summer camps in which Indian adolescents are paid to be counselors and elderly people talk about their Indian heritage.

3) Health career programs for high school students and scholarships for higher education.

Training of Indian students for meaningful careers and leadership positions was seen as a particularly promising preventive measure.

In support of these approaches, it was noted that pathology is mediated by lifestyle; a great deal of it is learned and has to do with self-image. Accordingly, such activities should not automatically be rejected as outside the scope of a preventive IHS program. The pathology that is presented to IHS for psychiatric care should be avoided.

Examples of effective prevention activities were listed at all three levels of care:

Primary - the model dorm at Toyei and parenting projects.

Secondary - the team approach described by the Billings representatives and first offender programs in several communities in New Mexico. (The latter are juvenile diversion programs utilizing family therapy. Staff of the Indian Children's Program have helped tribes in New Mexico to apply for funding of these programs.)

Tertiary - care of the chronically mentally ill in the community.

Other participants cautioned that some of the literature refutes the value of certain preventive efforts. The evidence on primary prevention, especially, is limited and equivocal. It was also noted that the validity of these findings could be

questioned; the wrong questions may have been asked or inappropriate samples used. Moreover, the research on the benefits of psychotherapy doesn't show consistently positive results.

It was also suggested that funding for the IHS alcoholism program might be spent more cost effectively if services were directed much more extensively toward women and children and were focused on prevention.

The Chronically Mentally Ill

There was extensive discussion of the chronically mentally ill, which reflected general agreement that IHS should not attempt to become a primary provider, but should utilize existing resources as fully as possible. Needs for these services were identified in several Areas.

It was noted that the chronically mentally ill can absorb a great deal of staff time, but that the program has a responsibility to arrange for treatment. The group endorsed the following recommendation:

> IHS should collaborate with and supplement other resources to assure continuity of care for the chronically mentally ill, including tribal resources under 638 contracts for consultation, liaison, treatment, and housing. In carrying out the liaison function, staff should use case management techniques. Local staff should be trained in the newest technologies, such as in psychopharmacology.

An example of community resources for partial care is the Community Mental Health Center. Given present resource constraints, it was suggested that perhaps the initial goal for all Areas should be narrowed and made more explicit, for example, to provide stabilization for acute cases. This kind of treatment involves an average length of stay of only 10 days, according to National Institute of Mental Health data. It was also noted that the problem of long-term case management should be addressed for all chronically mentally ill Indian patients.

Participants described the chronically mentally ill in the Navajo Area as including adults with organic brain damage, those with moderate-to-severe mental retardation, and chronic schizophrenics who are hospitalized periodically at the psychiatric unit at Gallup or the state hospital when they are in an acute phase. This population is a distinct one whom IHS can serve, but high quality care requires considerable follow-up with the families in between hospitalizations. The tribe has established a residential unit at Toyei for the developmentally disabled and the chronically mentally ill. It is funded from

multiple sources, not including IHS. Patients are allowed to stay indefinitely. Use of this facility has reduced the suicide rate, and it is seen as a substantial addition to the spectrum of care for mentally ill people in the Navajo Area.

The particular need cited for the Billings Area is custodial housing for patients after they are released from the state hospital.

Children and Adolescents

Throughout the plenary session, participants agreed that there are substantial unmet needs for a broad range of preventive and treatment services for children and adolescents, especially in outpatient settings. Differences were expressed in both Discussions III and VII, however, about the extent of need for inpatient units for children and whether IHS should expand its currently very small number of beds for children. As indicated in the goal statement on pages 42-43, the group recognized that inpatient services cannot be separated from the need for a system of care including all components. During Discussion III, participants proposed that IHS:

1) Investigate the possibility of allocating some staff to work only with children;

2) Continue to explore the desirability and feasibility of an inpatient facility for children, even though funds have never been appropriated for this; and

3) Reopen the dialogue with BIA concerning the interagency agreement.

The absence of the important link between teachers and mental health workers was mentioned several times. It takes extensive conversations between teachers and mental health staff to bring about the desirable level of cooperation, which is needed because the teachers' behavior and school performance have a strong impact on the mental health of students. A successful experience at the Chemawa (Oregon) boarding school, where two recreational therapists have been working since the Stewart model dorm was closed, was described. Since the therapists came, the dropout rate at the school has declined dramatically. Formerly, the rate ranged from 45-60 percent. During the first half of the 1983-84 school year, only 58 out of 400 (or 15 percent) have dropped out. (Many factors undoubtedly have contributed to the improvement; among these, the therapists' role probably has been important.)

It was noted that the current diagnostic code lacks a code for child development. This lack will be remedied in the next edition (DSM-4). This lack is significant because of the fact

that in treating adolescents, clinicians tend to overlook the developmental factors that have led to the current problems.

The importance of capacity to treat adolescents at the time of the first psychotic break was stressed.

A case was made that inpatient facilities for children are required to deal with at least three issues:

1) Admission of the patient at the time care is needed (as opposed to weeks later, if there is a long waiting list) and provision of an adequate amount of appropriate services. (In a general psychiatric service, adults tend to get most of the staff attention.)

2) Availability of appropriate training.

3) Assurance of continuity of care.

Other participants cautioned against further investment in inpatient care, arguing for a significantly greater emphasis on prevention for children and adolescents. (This point is summarized more fully under Prevention.)

Dr. Rhoades requested an action plan showing how IHS might do more for children nationwide. It was suggested that IHS should help to strengthen Indian families (as described in the Indian Child Welfare Act), and that agencies should establish closer ties at the program level, including ties with BIA schools.

Inpatient Care

During Discussion IV, the question of how best to care for patients who are violently mentally ill was raised by several people. The complex legal and resources issues facing IHS in connection with civil commitment were discussed.

Several people commented that financing of and access to inpatient psychiatric care were problems in some Areas. There is a great need for inpatient care and for resources within or outside the Indian Health Service to meet the need. Some participants argued that the IHS should not be in the business of providing inpatient care but should purchase it locally when needed. Others stated that community institutions aren't always responsive to Indians and that the IHS provides better psychiatric care for their Indian patients than they would receive elsewhere. It was also mentioned that direct provision of care allows the IHS to understand better the cause and nature of mental illness among Indian people. One participant suggested

a study of the amount of inpatient psychiatric services being provided to Indians by all sources and how they are financed as one basis for re-assessing policy in this area.

Dr. Rhoades indicated that he would like to have a plan for using currently underutilized medical beds in IHS general hospitals for psychiatric care for patients whose conditions do not require interventions by a psychiatrist on site. The plan should assume use of the existing hospital staff, most of whom will not have had training in mental health. Participants noted a need to clarify this assignment, and identified a number of possibilities and difficulties that should be considered. The following are examples of such topics:

- Policies on admission to and discharge from these beds -- These policies would need to be well documented and understood throughout the IHS system.

- Innovative methods for consultation -- An example would be a television hook-up between off-site psychiatrists and on-site staff.

- Training for staff -- For example, Oregon Health Sciences University staff trained nurses working in general hospitals to care for psychiatric patients.

- Accreditation -- IHS hospitals could jeopardize JCAH accreditation by treating patients with acute psychotic episodes without a psychiatrist present.

- Monitoring of patients -- Round-the-clock monitoring of psychiatric patients would put a tremendous drain on IHS hospital staff and the limited number of IHS psychiatric teams.

- Existing inpatient care -- IHS would need to know the level, locations, and sources of inpatient services delivered to the IHS-eligible population before expanding their availability through IHS resources.

- Patient characteristics -- Since psychiatric inpatients reflect many different populations and needs, these differences would need to be taken into account in treatment planning.

Clinical Standards

During Discussions IV and VI, participants urged that mental health guidelines and standards be issued.

Participants discussed these recommendations again in the context of the program mission for the future, and indicated that both standard measures of performance (measures of quality) and expected levels of performance (increments of quality) are needed. It was suggested that the job of drafting such mental health standards and setting expected levels of performance should be left to the Office of Mental Health Programs, and that an action plan should reflect this task.* The OMHP staff could base this work on earlier drafts that have not been issued officially, and on epidemiological data. The standards should include identification of and treatment for the most common psychiatric symptoms. These standards could serve as the framework for selection and supervision of staff, since it is possible to describe basic levels of care and train most people to deliver some of these services. The standards should also recognize the family as an important element in casefinding and treatment.

Treatment Methods

During Discussion I, Dr. Manson and Dr. Hammerschlag were asked to develop recommendations regarding the relationship between traditional healing methods and IHS mental health services.

In the concluding Discussion, participants returned to the topic of traditional healing. They seemed to agree that traditional methods help many Indian clients, but that Indian healers should not be asked to function as part of the IHS bureaucracy. There were some differences of opinion, however, about the degree of emphasis that clinical staff should place on these methods. Some traditional communities might regard a strong IHS emphasis on these methods as an intrusion.

It was urged that culture-specific therapies be reviewed to assess their effectiveness in treating mental disorders. For example, staff in the Billings Area have tried the talking circle in treating spouse abusers and believe it has been extremely effective. Young professionals benefit from observing some of these approaches, and the results should be published to inform practitioners in other locations.

Some participants were surprised to learn that psychiatrists at the Alaska Native Medical Center are seeing people who have attempted suicide and who seem not to have a

*The Office of Mental Health Programs has established a task force which is developing these standards and guidelines.

recognizable mental disorder as defined in DSM -3. The cause of these behaviors -- which could be, in part, internalized low self-esteem -- might be discoverable through carefully conducted research.

Alcoholism

Alcoholism was referred to numerous times during the conference as a disease that is combined with mental disorders in many Indian patients, and as a major cause of death. (See Discussions I and VI in particular.)

During Discussion VII, the main topic was a detoxification program in Seattle, in which some patients have been admitted 80 or more times in one year. Consequently, morale of the staff is low; they believe they are not doing an adequate job. The point was made that actually the staff are performing well, if one understands clearly what the job is. The patients are satisfied, and those who have used the service frequently are more satisfied than those who haven't. This experience, it was suggested, indicates that there is a miscommunication about the treatment process rather than that treatment of alcoholics is useless.

It was noted that, ideally, the conditions that result in alcoholism and/or mental illness should be prevented.

Environmental and Cultural Factors

These topics were addressed mainly as individual comments. No contrasting views were presented.

The increase in unemployment due to the closing of BIA boarding schools was noted as a potential contributing factor to mental disorders.

The stresses of life in an industrialized society, combined with the perceived decline in traditional Indian supports (such as changes in the extended family system), were indicated as contributing causes of widespread mental illness.

Contracting Under PL 93-638

During Discussion VI, the following suggestions were made:

1) IHS and BIA should bring their respective policies and regulations into conformance as fully as possible. The first step should probably be a meeting of senior officials from the two organizations to endorse the effort.

2) IHS should expand the role of mental health professionals in the planning and monitoring of 638 contracts. Their participation should begin early in the planning process.

Comments at the end of the conference were consistent with those made earlier, especially in Discussion VI. Participants emphasized the following concerns, among others: the critical need for standards relating to care and to personnel hired under 638 contracts; turnover in professional positions; the difficulty in reallocating funds to more effective or efficient services; and the need to assure coordination of primary care with mental health, alcoholism, and social services.

One participant urged IHS to welcome the 638 process as a unique opportunity to help strengthen tribal managerial capacities, which had been cited as a positive result during Discussion VI.

A technical point was raised concerning the use of carryover funds under 638 contracts. It was suggested that IHS examine the possibility, under existing (or amended) law and regulations, of offsetting new funding by any carryover funds from the preceding year.

Organization, Management, and Training

During Discussion II, participants emphasized the importance of continuing to recruit creative local people and fostering their skills in the mental health field.

During Discussions IV and VI, panelists proposed that recommendations from the Beiser/Attneave study should be implemented, as appropriate, especially those concerning recruitment, orientation, and training.

During Discussion IV, participants stated a need to clarify the role of IHS facilities and staff vis-a-vis the State in civil commitment practices, and to re-examine policies in relation to the most serious psychiatric cases. It was also noted that IHS should establish clear clinical lines of authority to support clinical decisions at all levels of the organization. Appropriate clinical supervision needs to be provided to all mental health staff, and the desirable level of supervision would require a significant amount of additional staff time.

During Discussion V, participants identified the need to train front-line clinic staff to recognize symptoms of mental disorders, and to tap the rest of the IHS system in ways that

will expand mental health services. They also suggested clarification of the reasons for the reduction of one-third in the number of positions assigned to the Mental Health Program. In addition, several people proposed moving the Office of Mental Health Programs to Headquarters East.

The group talked at length about organizational structure at the Headquarters, Area, and Service Unit levels, and how authority should be distributed among them. A major theme was the relationship between mental health, social services, and/or alcoholism staffs. One of the issues was whether these staffs should be formally integrated.

Three key organizational issues were identified:

(1) Whether to continue giving Areas and Service Units the option to organize mental health services as they wish within overall staffing limits.

(2) Relationship of the field structures to the Office of Mental Health Programs.

(3) Relationship of the Mental Health Program to the other IHS clinical programs.

It was pointed out that staffing constraints often necessitate integration of staffs in the human services fields at the Area or Service Unit levels. Differences in approach and credentials were cited as possible difficulties in establishing successful working relationships among people whose training was markedly dissimilar.

Dr. Rhoades asked the group to consider what would happen if the Mental Health Program did not function through a separate structure, but was integrated fully at all organizational levels. Participants responded that this change might result in a hospital focus rather than a community focus. IHS managers need to decide, ultimately, which emphasis is desired. One barrier to a hospital-based program is the reluctance of many IHS physicians to treat people with alcoholism and/or mental disorders. (It was also noted that the alcoholism program may not be perceived by most IHS staff as part of the IHS program until it is articulated more fully with the rest of the clinical services delivery system.)

In addition, mental health goals might not be acomplished as readily without an organization specifically devoted to them. Some participants stated that it is important to maintain a separate mental health program until the other clinical staffs take a more holistic view. As stated in the summary of Discussion V, however, positive experiences with integrated human services staffs were described.

Research and Evaluation

During Discussions IV-VI, participants made the following related suggestions:

1) IHS should do systematic evaluations of the Mental Health Program.

2) Regular Headquarters management reviews of Area mental health programs should be resumed. The findings should be taken into account in allocation of resources.

3) IHS should encourage and support research in the following areas:

   (a) The "crossover effect" that occurs at age 9.

   (b) The interface among mental health, alcoholism, and physical health services.

   (c) Causality of disease, with differentiation among such variables as Indian/non-Indian, urban/rural, reservation/non-reservation, and State/State.

   (d) Reasons for the predominance among Indians of the four leading causes of death that are psychosocial.

   (e) The cost effectiveness of a consultation/liaison model. (A literature review was proposed.)

4) IHS should find a better way to inform researchers about ongoing work and research findings.

5) IHS should develop a better way to transfer research findings into clinical applications.

Several people commented that IHS should conduct or fund certain types of research (such as epidemiological studies) and increase the emphasis on expanding knowledge about alcoholism and why it is so prevalent among Indian people. There was particular concern about alcoholism as a major factor correlated with mental disorders. On the other hand, the existence of positive research outcomes was noted. One participant suggested that research about the causes of alcoholism among Indians might be more fruitful if the population were divided into subgroups.

IHS was urged to fund and emphasize applied mental health research relating to Indian people. For example, the NIMH representative indicated that NIMH would not be able to continue devoting resources to these needs, as it had done historically.

The statements under Inpatient Care about the review of inpatient services and the value of IHS hospitals for gaining knowledge are also relevant here, as is the comment about culture-specific therapies under Treatment Methods.

Data System for the Mental Health Program

Participants agreed that a sound data system is a major element in assuring program accountability, and that much of the groundwork required for designing a good system has been completed.

It was suggested that the system be completed rapidly and include financial and personnel data, under the leadership of the Office of Mental Health Programs.

The only area of controversy concerned the extent to which the system should be designed at the program level, in light of the recent IHS Headquarters study of data policies. Dr. Rhoades confirmed that the system will be planned at the program level, but that it must be compatible with the IHS Information Systems Plan.

Closing Comments by Dr. Rhoades

This gathering has addressed topics of special interest and has demonstrated, once again, the excellence of IHS, which rests in its people. It has helped to underscore that IHS is a health organization. It has been a fruitful exercise that has provided a great deal of new information: for example, the increase in services to the Laguna Pueblo as a result of the 638 process. The discussion of the 638 experiences leads to a question as to whether IHS is the appropriate vehicle to foster the 638 process, much as the organization is committed to its intent. Perhaps this role should be put into the hands of an organization that could perform it better.

There are interesting topics that didn't get discussed fully. Reactions to these follow:

1) Role for professionals in the procurement process - IHS ultimately has no control over the management of the procurement process, and this lack interferes with what I call the "magic" of healing. When there has been an attempt to involve physicians in procurement, they have tended to treat it with disdain, perhaps because of previous experience. This topic warrants further attention.

2) Sharing of clinical experiences - A number of experiences described here should be shared more widely. For example, Dr. Winslow should publish his observations about suicide attempts in Alaska. Expansion of The Primary Care Provider is being considered to serve as a vehicle for teaching about IHS. Greater dissemination of shared or not-shared experiences is needed in our organization.

3) Dichotomies - The length of the list is intriguing. These are well encompassed in what I call the inherent contradictions of Indian life. A dichotomy shouldn't be permitted to grow between traditional medicine and scientific medicine. IHS must continue to focus the sharp, dissecting eye of science on the mysterious. On the other hand, I am negatively impressed by the subjugation of spiritual values by the primal position of science. Absence of a sense of moral values may have a great deal to do with the extraordinary growth in psychopathology so evident everywhere.

4) Genetic Causality - It would have been useful to have discussed genetics as a cause of psychopathology. This field remains in its infancy. I believe in 10 or 20 years, we will be startled by information about genetic mechanisms and disease.

5) The Family - The lack of discussion of the family was surprising, since there seems to be a growing consensus that destruction of the family is producing a vast amount of psychopathology. If natural families are disappearing, is it possible to invent a surrogate family?

6) Cultural ties - Dr. Ball's presentation confirmed, with statistics, a previous impression that many Indians are no longer maintaining close ties with their tribal traditions. This topic is one that tends to be avoided too often.

7) Suicide - It would be useful to know whether suicide is abnormal under all circumstances.

8) Accidents - There was very little mention of accidents, although they are a major, behaviorally-related cause of death. They're a mental health concern, in the broadest context. The injury that results is the end of a process and therefore should be susceptible to intervention.

9) Needs of children - The emphasis on children was impressive. The conference confirmed a previous belief of mine that there are "markers" early in life that reflect the future development of abnormal behavior.

10) Prevention - The discussion on prevention will require further thought. Perhaps there is enough knowledge to warrant some broader actions that should be put in place now.

11) Training of non-mental health IHS staff - The discussion about children suggests that most clinical encounters with mentally disturbed people are not with mental health staff. Something should be done to train IHS staff who don't have a mental health background to recognize behavioral problems in children.

12) Rates of mental illness by age - The dramatic increase in rates of mental illness among Indians after age 9 is startling.

13) Mission for mental health - The definition of mission may require some changes. One might regard the mission as "Stop suicides; stop homicides; stop accidents." If these goals were achieved, I believe that most of the other desirable changes in pathology would come about as a consequence.

14) Discouragement among IHS staff - This discouragement is temporary, one hopes -- a carryover from 1982 and the first half of 1983. Those in the trenches should know that there is at least one other person in IHS who cares a very great deal about their work, and recognizes the brilliance and dedication with which it is done. It is impossible to imagine a place that would be more interesting or more fun than IHS at the present time.

IHS MENTAL HEALTH PROGRAM REVIEW PLENARY SESSION AGENDA

January 17, 1984

8:30	Welcome to the Area	Stanley Stitt
8:35	Comments about the Purpose of the Program Review	Robert Graham
8:50	Comments about the Indian Health Service and Introduction of the Chairperson	Everett Rhoades
9:20	Welcome and Introduction	Chairperson, Irving Berlin
9:30	Discussion I. Mental Health Status of American Indians and Alaska Natives	H.C. Townsley, Moderator Joseph Ball Carl Hammerschlag James Shore
	A. Overall population size and characteristics	
	B. National data concerning the epidemiology of mental health problems, including trends; comparison with the general population	
	C. Data about particular Areas or localities	
	D. Cultural dimensions to be considered in planning and delivering mental health services for Indian populations	
10:30	Coffee Break	
10:45	Discussion II. History and Description of the Program	Billee VonFumetti, Moderator Robert Bergman John Bjork Lindsley Williams
	A. Legislative history	
	B. History of earmarked funding, by area and nationally, including amounts for direct vs. contracted services.	
	C. History of relationships with NIMH	
	D. Summary of the Headquarters, Area and Service Unit organizations	
	E. National summary of types of services funded, program models, workload and patient statistics	

11:45 Lunch

1:00 Discussion III. Services for Children and Adolescents — Johanna Clevenger, Moderator; Raymond Butler, David Heppel, Roland Johnson, John Thomas

A. Early research and Congressional testimony; nature of the problem

B. IHS efforts to address the problem

1. Ongoing services

2. Special projects

C. Joint IHS/BIA Indian Children's Program

2:30 Coffee Break

2:45 Discussion IV. Evaluation and Research Findings; Needs for Evaluation and Reporting Systems — Robert Walkington, Moderator; Morton Beiser, Joseph Bloom, William Douglas, Spero Manson, William Richards

A. Findings, from all sources, relating to the program

B. Ongoing studies

C. Measures of program success

D. Gaps in data, definition of needs by program area and organizational level, and priorities among data needs

E. Current systems for program monitoring and needs for changes

F. Data sources, processing capacity, and needs for changes

4:30 Adjournment

5:30 Social Gathering

January 18, 1984

8:30	Review of previous day's discussion	Irving Berlin
8:45	Discussion V. Organization and Funding	Jack Ellis, Moderator

A. Role of the Office of Mental Health Programs in relation to the Area Offices and Headquarters East

B. Current roles of the mental health staffs in relation to other components at the Areas and Service Units

Michael Biernoff
George Blue Spruce
James Felsen
Edward Kruger
Gordon Neligh
Margene Tower

C. Organizational relationships at the Area office and Service Units among mental health, alcoholism, and social services staffs

D. Current arrangements for budgeting, allocating and accounting for funds and positions associated with earmarked mental health funds, and related issues

1. Approaches for projecting needs for funds and staff to deliver or contract for services

2. Approaches for projecting needs for travel and training, and their relationship to the programmatic mission

E. Implications for the Mental Health Program of the effort to increase substantially third-party reimbursement; sources of reimbursement

F. Organizational implications of the jurisdictional, legal, health and financial issues relating to involuntary commitment

G. Impact of organization on the quality of clinical services

9:45	Coffee Break	
10:00	Discussion V. Continuation	

10:45 Discussion VI. Contracting Under P.L. 93-638 — Ronald Carlson, Moderator; Roland Johnson, William Richards, Stanley Stitt, Richard Winslow

A. Trends in levels of 638 contracting, exemplary contracts involving mental health services

B. Lessons learned from experiences with 638 contracting

C. Standards for hiring under 638 contracts; ways to help tribes maintain standards

D. Roles of mental health staff in establishing and evaluating mental health services under tribal contracts

12:00 Lunch

1:30 Discussion VI. Continuation

2:30 Coffee Break

2:45 Discussion VII. Rethinking the Mission and Future Direction of the IHS Mental Health Program — William Hunter, Moderator

A. Underlying concepts: for example, how "need" and "unmet need" should be defined; needs on reservations vs. in urban areas

B. Categories of services to consider in defining need

1. Prevention
2. Outpatient
3. Inpatient
4. Community consultation and education

C. Alternative programmatic emphases; prevention vs. cure; medical vs. public health model

4:30 Adjournment

January 19, 1984

8:30 Review of previous day's discussion — Irving Berlin

8:45 Discussion VII. Continuation

D. Relative priority among the various categories

E. Implications of the projected mission for particular types of facilities and services, including:

1. Care for the chronically mentally ill

2. Model dormitories

3. Special problems, such as prevention and treatment of drug abuse

4. Needs for services for children and adolescents

F. Implications of organization for the programmatic mission

10:00 Coffee Break

10:15 Discussion VII. Continuation

11:30 Lunch

1:00 Discussion VIII. Recommendations from the Plenary Session — Irving Berlin

A. Summary of highlights from all earlier Discussions

B. Development of recommendations by the group as a whole

3:15 Closing Comments — Everett Rhoades

Summary Statement Concerning Mental Health Services For Children And Adolescents

Irving N. Berlin, M.D.

Issues from a child psychiatric viewpoint that might be of interest for the IHS program include characteristics of a community mental health program for children, some models of effective prevention, and mental health consultation methodology.

At the local level, there is a tendency to fragment care by not providing sufficient consultation with schools. Potentially serious problems can be detected early if teachers and other school personnel are trained to recognize the symptoms of developmental interference at various levels. Depression, learning disorders, and overactivity of various causes which lead to more serious psychological and neurologic disorders later can be diagnosed and treated early in preschool and elementary school children. Once appropriate people are trained, one can implement treatment strategies.

It is important to identify abused children early. A recent study showed that 75 percent of the inmates at the state prison had been seriously abused as children. Any alert teacher can detect abused children both by their appearance and by changes in behavior (depression or extreme hyperactivity). Preschool-age children and their young parents are amenable to treatment. In New Mexico, there is a "Peanut Butter and Jelly" model for mothers and children in preschool. For the first three-four weeks, an aide is assigned to assure that mothers don't beat their children when the children misbehave. Mothers' groups help them understand and deal with common problems. Mothers are given special commendations for being helpful and supportive to their children, and staff provide good models for nurturant behavior toward children. Other models are effective for children in the first and second grades. There have been descriptions of group interaction models with children of these ages and their parents which have been helpful to families with abused children. Without such interventions, the schools and the social agencies wouuld be obliged to seek court action against the parents and foster care for the children. At the local level, there are a variety of effective approaches that should be considered which require some mental health consultation with educators and involvement in school programs. A variety of mental health, social agency, and school counselors can be taught to deal with abused children in a consistent way, and to avoid getting involved punitively during the children's provocative behaviors.

At the regional level, the most inexpensive treatment setting is the group home. In this type of facility, children and parents are treated in groups (group sessions having been found to be more effective than individual sessions). Cooperative games are an important mode of providing treatment for young children. Preadolescents and adolescents also respond to group therapy and to peer pressures in a group home.

The impact of milieu therapy in a group home, residential treatment center, or psychiatric hospital is critical. Abused children generally have a massive lack of trust of adults. A supportive school program is also essential to the child's learning to feel competent. Mental health consultation can help teachers become better able to identify children in trouble and to provide supportive concern once treatment begins. Consultation also helps educators with how to approach a troubled child from an educational standpoint; therefore, learning becomes a way of enhancing self-esteem and being valued and praised by adults.

Children need a spectrum of services so that continuity is provided. Hospitalization is required for some with acute psychiatric disturbance, but inpatient stays should be brief and followed by care in residential settings closer to home communities.

The severe problems of some adolescents come not from the turmoil of the adolescent period itself but from developmental deficits due to conflicted relationships with disturbed, depressed, or alcoholic parents that preceded adolescence. These deficits make the adolescents vulnerable during a stressful period.

The National Commission on Children and Youth has tested a successful approach with adolescent girls. In four pilot programs, 120 high-risk girls who were abusing alcohol and/or other drugs, were having trouble with their families, and were learning poorly, were identified. The girls were employed to work as counselors and helpers in day care programs. The girls learned quickly how to care for children of various ages and how to identify the most disturbed children. They were required to take a course in child development in order to collect their pay. Through this experience, they learned to understand themselves better and learned to become observant, understanding, and caring young people, rather than at-risk young women.

After five years, some of these girls did marry and become pregnant both in and out of marriage. Among these mothers, the abuse rate was 5 percent; among the control group, it was 40 percent.

There have been similar programs for girls who are already pregnant. They have participated in a child care program; husbands have also joined in as the mothers obviously enjoyed what they

learned about themselves. They have also become part of a group of new mothers who have worked with their own and other infants in the community nursery. There they have learned effective parenting skills.

A first-offender model is now used on several Indian reservations. In these programs, youths involved in drug and/or alcohol abuse are sentenced, with their families, to participate with a group of families who are in counseling together. The purpose is to help the family members learn to talk to each other, partly by learning with the help of counselors how to role play another person in the family caught up in the family conflict. Then each family member gets a sense of how others feel and react to family problems. This type of program has been proven to be the most cost effective of those prevention models dealing with early discovery of substance abuse.

My major thesis is that early intervention and prevention models are available to help with a wide variety of psychological problems in early childhood and adolescence. Most of these models require family involvement. They also require education and training of a wide variety of helping persons in social agencies, in health, mental health, or education, and in the courts.

Attachment C

IHS Mental Health Plenary Session Participants

Indian Health Service

Michael P. Biernoff, M.D.	Mental Health Branch Chief, Albuquerque Area
John W. Bjork, A.C.S.W.	Mental Health Branch Chief, Oklahoma City Area
George Blue Spruce, Jr., D.D.S.	Area Director, Phoenix Area
William Douglas, Ph.D.	Office of Mental Health Programs, Headquarters West
Jack Ellis, M.D.	Former Deputy Director and Chief Medical Officer, Albuquerque Area; currently on detail to the Office of Mental Health Programs. (As of April 1, Dr. Ellis is Acting Director, Office of Mental Health Programs.)
James D. Felsen, M.D.	Acting Director, Division of Program Operations and Chief Medical Officer, IHS. (Dr. Felsen is now Director, Division of Federal Employee Occupational Health, Bureau of Health Care Delivery and Assistance, HRSA.)
Carl A. Hammerschlag, M.D.	Chief of Psychiatry, Phoenix Indian Medical Center
Albert B. Hiat, Ph.D.	Acting Director, IHS/BIA Indian Children's Program
William B. Hunter, III, M.D.	Deputy Director, Office of Mental Health Programs
Edward Kruger	Service Unit Director, Ada, Oklahoma
Peter M. Nakamura, M.D.	Deputy Area Director and Chief Medical Officer, Portland Area

Gordon L. Neligh, M.D.	Area Psychiatrist, Billings Area (Since March, Dr. Neligh has been Acting Director, Clinical Services for the Area.)
Luana Reyes	Director, Division of Program Formulation, IHS. Former Director, Payallup Health Authority and Director, Seattle Health Board. (Ms. Reyes is now Acting Associate Director, Office of Planning, Evaluation and Legislation, IHS.)
William Richards, M.D.	Mental Health Branch Chief, Alaska Area
Everett R. Rhoades, M.D.	Director, Indian Health Service
C. Stanley Stitt, Jr., D.D.S.	Area Director, Portland Area
John B. Thomas, M.D.	Chief, Mental Health Service, Indian Medical Center, Gallup
Margene V. Tower, R.N., M.S.	Mental Health Branch Chief, Billings Area (Ms. Tower is now Area Behavioral Health Officer.)
H.C. Townsley, M.D.	Director, Office of Mental Health Programs. (As of April 1, Dr. Townsley is Area Director, Oklahoma City Area.)
Billee VonFumetti, R.N., M.S., M.P.H.	Mental Health Branch Chief, Portland Area
Richard Winslow, M.D.	Chief, Psychiatry Services, Alaska Native Medical Center, Anchorage
Marian E. Zonnis, M.D.	Mental Health Branch Chief, Navajo Area

Bureau of Indian Affairs

Raymond B. Butler, M.S.W.	Chief, Division of Social Services, Bureau of Indian Affairs
Roland Johnson	Superintendent, Laguna Agency Laguna, New Mexico. Former Director, IHS/BIA Indian Children's Program

Indian Practitioners

Joseph W. Ball, M.D.	Psychiatrist in private practice in Portland, Oregon. Psychiatric consultant to the Portland Urban Indian Health Program.
Johanna Ghe-e-bah Clevenger, M.D.	Adult and child psychiatrist in private practice in Dallas. President, Association of American Indian Physicians.
R. Dale Walker, M.D.	Chief, Alcohol Dependence Treatment Program, Seattle Veterans Administration Medical Center. Also holds an appointment at the School of Medicine, University of Washington. Research on Indian alcoholism and mental health issues. Chairman, American Psychiatric Association Committee on Indian and Alaska Native Affairs.

Researchers in Indian Mental Health

Morton Beiser, M.D.	Professor and Head, Division of Social and Cultural Psychiatry, University of British Columbia, Vancouver. Principal investigator on 1973-1976 studies on the IHS Mental Health Program.

Robert L. Bergman, M.D.	Clinical Associate Professor, Department of Psychiatry and Behavioral Sciences, University of Washington. Director of the IHS Mental Health Program 1969-1975.
Irving N. Berlin, M.D.	Chief, Division of Child Psychiatry, Department of Psychiatry, University of New Mexico, School of Medicine. Has published widely in the field of child psychiatry. Has published widely in the field of child psychiatry.
Joseph D. Bloom, M.D.	Vice Chairman, Department of Psychiatry, Oregon Health Sciences Unviersity. Research on mental health issues, including studies of Alaska Natives. Former IHS Area Psychiatrist.
Spero M. Manson, Ph.D.	Associate Professor and Director, Social Psychiatric Research, the Oregon Health Sciencea University. Former Research Director, National Center for American Indian Mental Health Research, Oregon Health Sciences University.
James H. Shore, M.D.	Professor and Chairman, Department of Psychiatry, Oregon Health Sciences University. Also Assistant Dean for Curriculum, School of Medicine, OHSU. Has published a number of articles about Indian Mental Health. Former Mental Health Branch Chief.

Other Federal Representatives

Ronald H. Carlson	Chairman, Steering Committee for the Program Review. Associate Administrator for Planning, Evaluation and Legislation, HRSA.
Robert Graham, M.D.	Administrator, HRSA
David Heppel, M.D.	Former Director of the IHS/ BIA Indian Children's Program. Now Chief for Child and Adolescent Primary Care Services, Division of Maternal and Child Health, Bureau of Health Care Delivery and Assistance, HRSA.
Robert A. Walkington	Director, Office of Program Development, Bureau of Health Professions, HRSA. Has extensive experience in evaluation of Federal health programs and in program reviews.
Lindsley Williams	Director, Office of Policy Development, Planning and Evaluation, NIMH. Has served as a senior coordinator between NIMH and IHS for several years.

National Indian Health Board

Jake L. Whitecrow	Executive Director, National Indian Health Board.

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Mental Health Recommendations

to

Everett R. Rhoades, M.D.

Director, Indian Health Service

from

Ad Hoc Group on Mental Health

July 9, 1984

Introduction:

The Ad Hoc Group on Mental Health was charged by Dr. Everett Roades to review the recommendations of the Indian Health Service Mental Health Program Review and Plenary Session of January 17-19, 1984 and to recommend future actions by the Indian Health Service for Mental Health Programs. The group met on June 6-7, 1984 in Portland, Oregon. Group members were: James Shore (chairperson), Edward Kruger, Margene Tower, Richard Winslow, and Anabel Crane (staff person). H.C. Townsley and Dale Walker were unable to attend because of scheduling conflicts but had an opportunity to review the recommendations.

Chairperson:

James H. Shore, M.D.
Professor and Chairman
Department of Psychiatry
Oregon Health Sciences University

Committee Members:

Edward Kruger
Service Unit Director
Ada, Oklahoma

Margene V. Tower, R.N., M.S.
Area Behavioral Health Officer
Billings Area

Richard Winslow, M.D.
Chief, Psychiatry Services
Alaska Native Medical Center
Anchorage

H.C. Townsley, M.D.
Area Director
Oklahoma City Area

R. Dale Walker, M.D.
Chief, Alcohol Dependence Treatment Program
Seattle Veterans Administration Medical Center

Anabel Crane, Staff to Ad Hoc Group
Health Resources and Services Administration
Rockville, Maryland

Recommended Actions:

The group systematically reviewed the proceedings and recommendations from the Mental Health Plenary Session of January 17-19, 1984. Nine action recommendations were developed for the Director of Indian Health Service. The group recommends that the Director of Indian Health Service implement the following:

1) Endorse and support the comprehensive mission statement for the Mental Health Programs of Indian Health Service (see comments on the recommended actions).

2) Transfer the position of Director of Mental Health Programs to the Rockville headquarters office of Indian Health Service.

3) Appoint a standing Indian Health Service Mental Health Council.

4) Direct the development and adoption of an integrated data system for mental health programs.

5) Direct a closer collaboration between mental health and alcoholism programs within Indian Health Service and coordination of both with the relevant social services programs.

6) Appoint a task force on children and adolescents to develop a national plan to address mental health issues for Indian youth, with an emphasis on prevention.

7) Support the development of appropriate involuntary commitment processes for the treatment of seriously mentally ill patients who are in need of such treatment.

8) Stimulate the development of mental health research and program evaluation to guide the direction of mental health program development within Indian Health Service using all available resources including Indian Health Service funds, the National Institute of Mental Health, and universities.

9) Request that the National Institute of Mental Health initiate a review of culturally specific traditional medicine treatments among American Indians.

Comments on the Recommended Action Statement:

1) The mission statement for the Mental Health Programs of Indian Health Service supports development of a comprehensive, community-based mental health delivery system.

> "The Mental Health Program of Indian Health Service should be guided by a principle of developing model, culturally sensitive, comprehensive community mental health delivery systems with direct care, consultation/liaison, and prevention. Direct care should include outpatient, crisis, inpatient, and other services. Consultation/liaison should include collaboration with Indian communities, education and training, and active liaison with medical, alcohol, and social services. Prevention efforts should be directed at multiple levels with special attention to Indian children and adolescents.
>
> Mental health staff will serve as advocates for improved mental health services for American Indian and Alaska Native peoples within Indian Health Service and with all appropriate Federal, state, and local resources. The program will facilitate evaluation and research to guide future developments."

It is obvious that the Indian Health Service budget for Mental Health Programs is inadequate to meet the goals of a comprehensive mental health delivery system. The system should be supported with all available resources including IHS direct mental health funds, service unit, area office, tribal, and outside funds from federal, state, and community mental health agencies. This Ad Hoc Group strongly supports the structure of an identified Mental Health Program with service coordination and integration in the Office of Program Operations of IHS at the national, area office, service unit, and tribal program levels. The Director of Indian Health Service and the Mental Health Program Director should use every opportunity to identify additional funding opportunities to support the development of a comprehensive mental health delivery system both within Indian Health Service and within tribally sponsored programs. Systematic area office reviews should be conducted reinforcing the development of a comprehensive range of services.

2) The Ad Hoc Group reviewed the extensive discussions from the plenary session about the move of the Mental Health Program Director to IHS Headquarters. The Group strongly endorses this transfer. While active collaboration with Headquarters West, Area Offices, and Service Units is a central responsibility of the Mental Health Program Director, it is essential that the Director be integrated fully into IHS Headquarters and function within the newly reorganized Office of Program Operations.

3) The Ad Hoc Group proposes the appointment of a National Indian Health Service Mental Health Council to be appointed by the Director of Indian Health Service and serve under the chairmanship of the Director of Mental Health Programs. This National Council should serve in an advisory role for planning, development, evaluation, and advocacy. It should be composed of

both intramural and extramural members. The intramural membership should include the area office mental health branch chiefs, a representative from the Office of Program Operations, and an Indian mental health paraprofessional. The extramural membership could be composed of representatives from several important Indian mental health organizations and individuals with special experience. Extramural members could be appointed for a two to three year term. There could be three to four members from Indian mental health professional groups (psychiatry, psychology, social work, and nursing), one with relevant mental health research experience, one with previous experience in the Indian Health Service Mental Health Programs, and one from the National Indian Health Board. The Council would be chaired and charged by the Director of Mental Health Programs. It could deal with the many ongoing issues of planning, program development, evaluation, and advocacy. Several such issues were identified in the mental health plenary session: for example, the study of inpatient psychiatric services provided to American Indians and the potential to utilize medical beds in IHS general hospitals; mental health staff recruitment, orientation, training, and retention; development of tribal programs and P.L.93-638 guidelines; clarification of clinical lines of authority for the area mental health consultants to support the comprehensive mission statement for development of the mental health delivery system; development of clinical standards; and many of the issues addressed in the other action recommendations.

4) The Ad Hoc Group endorses the development of an integrated mental health data system that is compatible with other clinical data systems being used in Indian Health Service. The current mental health-social service data system should be replaced by a system that is integrated with the other IHS patient care information system (s) and which includes standard mental health nomenclature.

5) The Ad Hoc Group recognizes the extensive association of alcohol abuse with major mental health problems, including four of the leading causes of death. We recommend administrative involvement to insure effective collaboration between the mental health and alcoholism programs within the Office of Program Operations, including appropriate coordination with relevant personnel in IHS social services and with IHS clinicians.

6) The Ad Hoc Group strongly supports recommendations from the plenary session to emphasize prevention efforts, especially with Indian youth. We recommend the appointment of a time-limited Indian Health Service Mental Health Taskforce on Children and Adolescents to focus on the needs of high-risk Indian adolescents. This Task Force could propose a model for a national program of youth-oriented mental health services through the identification of model pilot projects, staff training, funding opportunities, systems for service delivery, and steps for implementation. Important areas include integrity of the Indian family, school adjustment, substance abuse, and suicidal behaviors.

7) The Ad Hoc Group urges active attention to collaboration with tribal and other resources to assure continuity of care for the chronically mentally ill. The Indian Health Service should recognize the need for innovative

community services for chronic patients as a part of a comprehensive mental health delivery system. IHS should advocate with tribal, state, and other federal authorities for the adoption of policies to insure approriate care and custody for patients needing short-term civil commitment. A recent NIMH funded research project on American Indian civil commitment issues provides guidelines for this approach. The Group also endorses the statement from the plenary session:

> "The Indian Health Service should collaborate with and supplement other resources to insure continuity of care for the chronically mentally ill, including tribal resources under P.L. 93-638 contracts for consultation, liaison, treatment, and housing. In carrying out the liaison function, staff should use case management techniques. Local staff should be trained in the newest technologies, such as psychopharmacology."

8) The Indian Health Service should support and encourage mental health research and program evaluation in multiple areas to discover the etiology of the major mental health problems of Indian people. Research priorities should include four of the leading causes of death from psychiatric and substance abuse behaviors including suicide, homocide, accidents, and the effects of alcoholism. Research also should focus on effective prevention techniques, especially with Indian children and adolescents. The Indian Health Service should both sponsor, conduct, and stimulate involvement in mental health research with the Mental Health Program, interested tribes, the National Institute of Mental Health, and universities.

9) Because of the importance of traditional Indian medicine for American Indian peoples, the Director of IHS and the Director of Mental Health Programs should request that the National Institute of Mental Health support a systematic review of the known effects of culturally specific therapies.

Attachment E

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Health Resources and
Services Administration
Rockville MD 20857

Jack Ellis, M.D.
Acting Director, Office of
Mental Health Programs
2401 Twelfth Street, N.W.
Albuquerque, New Mexico 87102

Dear Dr. Ellis:

Since receiving the report of the Mental Health Plenary Session, I and others have given the recommendations careful consideration. Dr. Graham and I now want to give you our response.

As you know, the draft report reflected about 40 recommendations, involving actions that would vary widely in nature and scope. In view of the number and diversity of these suggestions, I asked a small group of participants to convert the list into a relatively small number of action steps, and to suggest some approaches to implementation. The group submitted their report in July; a copy is enclosed for your information. Our responses address the nine recommendations in that document, which encompass almost all of the original ones. (The few recommendations from the original set that are not included in the nine will be dealt with internally.) As indicated below, I have adopted all of them, except for formation of a standing Mental Health Council.

1) Endorse and support the comprehensive mission statement for the Mental Health Programs of Indian Health Service (IHS).

   We accept this recommendation and have begun its implementation through the Acting Chief, Mental Health Programs Branch, Dr. Jack Ellis. Dr. Ellis and Dr. Hunter, the Deputy Branch Chief, are in the process of visiting each Area/Program Office to review mental health activities there. We are actively attempting to strengthen the integration of the Mental Health Program with all other programs of IHS, both in the Headquarters Office of Program Operations and throughout the field structure. I see this increased emphasis on integration as one of the major positive outcomes of the program review.

2) Transfer the position of Chief of Mental Health Programs to the Rockville Headquarters Office of Indian Health Service.

   The new position description for the Chief of Mental Health Programs specifies its location at IHS Headquarters. The organization is a Branch of the Division of Clinical and Environmental Services, Office of Program Operations. I believe that locating the director of Mental Health Programs in Rockville will further promote the increased emphasis on IHS behavioral health programs.

3) Appoint a standing Indian Health Service Mental Health Council.

I recognize the value of periodic advice from a group who can view a program from a broader perspective than that of staff charged with day-to-day operational concerns. I believe, however, that a permanent Council might tend to develop such a limited focus that its value would be diminished. Accordingly, I plan instead to convene a small group on an ad hoc basis to give me their assessment of problems and accomplishments, and suggest strategies. I will, of course, continue to be in regular contact through other forums with many of the people suggested for membership on the Council. In conjunction with these individuals, the Office of Program Operations will oversee the kinds of planning, program development, evaluation, and advocacy concerns on which the Council would have advised.

4) Direct the development and adoption of an integrated data system for mental health programs.

An integrated data system for all IHS programs is being developed with coordination by Dr. Walter Wolford, in the Office of Administration and Management. Mental health data needs, to be identified by the Mental Health Programs Branch, will be included.

5) Direct a closer collaboration between Mental Health and Alcoholism Programs within Indian Health Service and coordination of both with the relevant Social Services programs.

The inclusion of both Mental Health and Alcoholism Programs in the Office of Program Operations facilitates the integration of these activities. In addition, as you may know, we are currently conducting a program review of Alcoholism, and expect to hold a Plenary Session next spring. We also are considering a review of IHS Medical Social Services during FY 1985 as a further basis for administering these programs in the most productive manner possible. I recognize the value to Indian people of the skills and insights represented by staff trained in each of these areas, and the need to provide these services so as best to meet the needs of our patients who may have multiple problems that cross disciplinary lines.

6) Appoint a task force on children and adolescents to develop a national plan to address mental health issues for Indian youth, with an emphasis on prevention.

I agree strongly with this proposal, and intend to increase the emphasis on services for these groups in all IHS programs. I will ask the Acting Chief of Mental Health Programs to form a time-limited task force to begin work as soon as possible.

7) Support the development of appropriate involuntary commitment processes for the treatment of seriously mentally ill patients who are in need of such treatment.

Efforts to address this issue are underway. I will ask the Acting Chief of Mental Health Programs to research the status of services being provided and submit a plan for dealing more effectively with the complex problems of involuntary commitment.

8) Stimulate the development of mental health research and program evaluation to guide the direction of Mental Health Program development within Indian Health Service using all available resources including Indian Health Service funds, the National Institute of Mental Health, and universities.

I will ask the Acting Chief of Mental Health Programs to review this recommendation, determine the current status of research within the IHS, and develop a plan in response to this recommendation. I am investigating the possibility of increasing IHS-sponsored research to address specific clinical and behavioral health needs.

9) Request that the National Institute of Mental Health initiate a review of culturally specific traditional medicine treatments among American Indians.

I endorse this recommendation, also, and will contact the National Institute of Mental Health to arrange for the review.

I want to thank you again for participating in this review of the Mental Health Program. As you can see from these positive responses, I found your views and recommendations very useful. The Plenary Session led to some new proposals and undoubtedly prompted earlier adoption of some changes that had been suggested in other forums.

Dr. Graham joins me in sending thanks and in welcoming any further comments you may have.

Sincerely yours,

Everett R. Rhoades, M.D.
Assistant Surgeon General
Director, Indian Health Service

Enclosure

Attachment F

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Date November 20, 1984

From William B. Hunter, M.D., Deputy Chief, Mental Health Programs Branch

Subject Response to recommendations of Ad Hoc Group on Mental Health

To Craig Vanderwagen, M.D.
Acting Director, Division of Clinical & Environmental Services

The following are actions that have been implemented or are under consideration for implementation by the Mental Health Programs Branch arising from the Ad Hoc Group on Mental Health.

1. Endorse and support the comprehensive mission statement for the Mental Health Programs of Indian Health Service.

There has been an intensive movement to develop better liaison and communication between the Mental Health Program Branch and each of the IHS Area/Program offices. This movement has taken the form of visits to the 10 of the 12 Area/Programs arranged through the mental health Branch Chiefs in the area. Each visit has included key administrative personnel in the Area/Program as well as visits to individual Service Units and/or Tribes for direct discussion with tribal leaders and health personnel. Furthermore a broad redefinition of the Quality Assurance position in the Mental Health Programs Branch is underway and a position will shortly be advertised that will provide tribal programs with a consultation resource in quality assurance (including risk management and diagnosis related groups). Finally, in a special edition of the Listening Post, the discussions of the Plenary Review Session were published widely. In the same forum, the recommendations of the Ad Hoc Group and the actions taken will be published in the next edition.

2. Transfer the position of the Chief of Mental Health Programs Branch to the Rockville Headquarters Office of Indian Health Service.

This position has now been advertised with the understanding that it will be located in Rockville.

3. Appoint a standing Indian Health Service Mental Health Council.

No specific action on this recommendation has been taken at this time. There has, however, been a concentrated effort to strengthen ties with Indian psychiatrists through increased professional liaison with this group.

4. Direct the development and adoption of an integrated data system for mental health programs.

Hard and software have been acquired by the Mental Health Programs Branch to explore the development of the IHS-wide planned integrated data system. The Mental Health Programs Branch has beeen verbally designated to coordinate a Professional Specialties Group (PSG's) and formal, written designation permitting implementation should be forthcoming shortly.

5. Direct a closer collaboration betwen mental health and alcoholism programs within Indian Health Service and coordination of both with the relevant social services programs.

An informal agreement will of necessity await the appointment of a Chief of the Mental Health Programs Branch and completion of the Alcoholism Program Review. The Mental Health Programs Branch has actively supported the Fetal Alcohol Syndrome (FAS) Program, and is currently exploring mechanisms for increasing this support to broaden the impact of the FAS Program.

6. Appoint a task force on children and adolescents to develop a national plan to address mental health issues for Indian youth, with an emphasis on prevention.

Preliminary discussions are underway with the IHS Senior Clinician in Pediatrics, the appropriate personnel in the Department of Education, the Bureau of Indian Affairs and University Division of Child Psychiatry to begin to address this issue. Furthermore, a draft of an Interagency Agreement between the BIA and IHS has been developed by an IHS task force and is now ready for study and consideration by the BIA.

7. Support the development of appropriate involuntary commitment processes for the treatment of seriously mentally ill patients who are in need of such treatment.

This is a complex issue. Discussions with the Mental Health Branch Chiefs in the Areas visited have included this issue and the Mental Health Programs Branch has been actively involved in the attempts to clarify legal issues arising from the White vs. Califano case in the Aberdeen Area. However, these efforts would be more effective with some coordination with similar efforts at Headquarters East.

8. Stimulate the development of mental health research and program evaluation to guide the direction of mental health program development within Indian Health Service using all available resources including Indian Health Service funds, the National Institute of Mental Health and universities.

The Mental Health Programs Branch has worked to strengthen collaboration with university mental health professionals at the University of Washington, University of Oregon and University of New Mexico. The Mental Health Programs Branch is actively involved in a mental health needs assessment of Indian children. This project, under the auspices of the Indian Children's Program, is in collaboration with the Albuquerque and Phoenix Areas. Discussions are currently underway with the Program Director, Office of Research and Development to explore areas of collaboration in mental health promotion. Finally, a Mental Health Programs Branch Manual, to be followed by standards and guidelines for mental health, is being actively developed.

9. Request that the National Institute of Mental Health initiate a review of culturally specific traditional medicine treatments among American Indians.

Discussions with appropriate personnel in the NIMH concerning this issue, among others, have been scheduled.

William B. Hunter. M.D.